



# Trends in the Human Service Landscape

## Massachusetts Council Of Human Service Providers

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## Introduction

The Massachusetts Council of Human Service Providers is a statewide association of health and human service agencies. Founded in 1975, the Providers' Council is the state's largest human service trade association, representing hundreds of agencies across the field of health and human services that work with vulnerable populations.

In June 2011, the Providers' Council asked Public Consulting Group (PCG) to examine national trends in the purchase and provision of services across the human service sector. PCG is a privately held consulting firm serving state and local health and human services programs. With approximately 1,000 professionals in 35 offices around the U.S., Canada, and Europe, PCG offers a wide range of management consulting, technology, and research solutions to help agencies achieve their performance goals and better serve populations in need. PCG regularly updates its knowledge of industry best practices to deliver leading and promising approaches to its clients.

The objectives of this report are to provide:

- A concise overview of the major growth areas for human service provision and procurement at the state level.
- A review of ground-breaking strategies and significant trends elsewhere in the country to address the emerging issues in this area.

## **Introduction to Public Consulting Group, Inc. (PCG)**

Public Consulting Group, Inc. (PCG) is a management consulting firm that primarily serves public sector health and human services, education, and other state and municipal government clients. Established in 1986 with headquarters in Boston, Massachusetts, PCG operates from 35 offices across the U.S. and in Montreal, Canada, and Lodz, Poland. The firm has extensive experience in all 50 states, clients in six Canadian provinces, and a growing presence in the European Union.

Because PCG has dedicated itself almost exclusively to the public sector for nearly 25 years, the firm has developed a deep understanding of the trend within the human services industry. We have helped numerous public sector organizations refine business processes, maximize resources, make better management decisions, introduce performance measures, ensure federal and state compliance, and improve client outcomes. Many of PCG's more than 1,000 employees have extensive experience and subject matter knowledge in a range of government-related topics, including child welfare, Temporary Assistance for Needy Families (TANF), Welfare to Work (WtW), Medicaid and Medicare policy, special education, literacy and learning, and school-based health services finance.

# Executive Summary

## Synopsis

This report addresses three major issues facing human service providers and public agencies today:

- 1) The growing emphasis on customer-centric care
- 2) The decentralization of services and associated rise of coordinating bodies
- 3) The changing face of payment models in the field.

**Customer-centrism** is part of the greater human services “culture change” toward person-centered care, i.e., serving individuals in the least restrictive environment, shifting toward locally based services, and meeting the self-determined needs of individuals in ways that are convenient for them.<sup>i</sup> Overall, customer-centrism is a movement to meet people “where they are at” through both community-based and consumer-directed care models. With the alternative to remain in the community and receive personal care services in their home, customer-centric services offer more familiar, often more comfortable options for customers who might otherwise be served in a long-term facility. A major piece of this effort is the encouragement and growth of **participant-directed services**, which give consumers (and in some cases their families) enhanced control over the services they receive.

**Decentralization** of human services is a long-unfolding trend that has recently given rise to **coordinating bodies** in some areas of human

services. These entities are distinct from purchasing agencies and charged with the management of increasingly localized services. This model coordinates vendors and in some cases manage care for people with multiple health and social needs. Such a framework requires extensive cross-collaboration in the delivery and coordination of services across health care and community organizations. Coordinating bodies explored in this report include **Child Welfare Lead Agencies, Early Intervention Local Interagency Coordinating Councils, Fiscal Intermediaries, and Accountable Care Organizations**.

**Payment models** in human services are impacted by the current economic climate and changes in service focus. With state budgets tightly constrained, state agencies must look for ways to keep costs under control while still meeting the needs of constituents and honoring contracts. This pressure, along with the customer-centric developments in the field and an increasing emphasis on outcomes, has raised the question of how states will structure their payments. This report discusses the distinguishing characteristics, benefits, and drawbacks of the major payment models: **Fee for Service, Capitation, Managed Care, and Pay for Performance**.

## ***Takeaways for Providers***

The increase in customer-centric care models and programs, the growing use of coordinating bodies that fill a space between state governments and providers, and the importance of determining how services will be reimbursed significantly impact human service providers. Understanding what programs and changes have worked in other states, as well as what has failed can assist the provider community in determining how to prepare for, respond to, and promote models of change that are inclusive of their concerns and priorities. Following is a summary of possible outcomes and steps for human service providers.

- The rise of participant-directed services puts pressure on providers to communicate with a decentralized market of individuals seeking services. Successful providers will find points of entry to individual clients through outlets such as service directories, direct marketing, and other communications strategies. In some successful state programs service directories currently exist – in others there is an opportunity for providers to help drive the process of how state agencies and coordinating bodies will share information about their services with prospective clients.
- Quality rating and consumer review information is becoming wide spread in some aspects of human services, such as child care provision and health care. Over time we can expect to see a rise in quality rating and other information to help consumers make choices in consumer-centric models. There is an opportunity for the provider community to become involved early to lead efforts to design and develop these rating/information sharing activities.
- As clients transition out of institutional care into home and community-based settings, participant-directed services represent a substantial growth opportunity in some areas of human services including lower-skilled/lower education workers than historically used. There is an opportunity for providers to help develop this workforce through screening, oversight, training and professional development.
- From lead agencies and interagency councils to fiscal intermediaries and new forms of managed care, coordinating bodies are changing the way providers interact with governing agencies. Lessons learned from other state implementations can be used to help define what future coordinating bodies might look like and how they might operate.
  - In their fiscal arrangements with coordinating agencies, or generally during times of system change, the ability for providers to rollover state revenue from one year to the next can serve as a safety net to allow providers to ready for changes in service demands.

- For newly developed coordinating agencies to run smoothly, or to support other major systems change, it is important that providers have adequate time to develop the infrastructure, relationships, and processes they need to operate effectively in the long run.
- New payers, payment systems, and eligibility criteria will benefit providers with efficient and effectively administered billing operations.
- ACOs represent a promising structure of provider-led health care, and providers with service profiles that fall under the umbrella of health care will benefit from building relationships with leading organizations and seeking out details about IT requirements for connecting across systems. As ACO models are developed providers can play a role in determining how outcomes will be measured, how providers will technologically connect across systems, and what kind of funding release valves might be developed to deal with unforeseen costs during transition.
- The drawbacks of fee for service payments now evident in the health care field forecast a similar trend towards proscription global and/or capitated payments in human services that will bring increased risk to providers.
- If set at fair rates, a shift towards proscription/global payments would afford providers at least some opportunity to invest in systems upgrades and other cost-saving innovations that will help them succeed in the persistently difficult economic climate.
- As the interest in and funding for Social Impact Bonds grows, it is important for providers to understand the structure of these bonds. Social Impact Bonds emphasize performance outcomes. As these models are being considered and developed in the U.S., providers can play a role in helping to determine how performance outcomes will be measured, and in determining what types of IT or other infrastructure supports are necessary to participate in these opportunities.



## Service Landscape

Two trends in the human service landscape are driving the major changes facing human services agencies and providers:

- 1) The growth in certain specialized populations
- 2) The impact of the budget and financial constraints facing state agencies.

### **Growth of Key Populations**

Driving changes in the human services sphere is the rapid growth of several high-needs service populations—including individuals with Autism Spectrum Disorder (ASD), individuals with Traumatic Brain Injury (TBI), veterans, and the elderly, many of whom would formerly have been served in institutions.

**Autism Spectrum Disorder (ASD):** Individuals with ASD experience a wide range of conditions that occur in all racial, ethnic, and socioeconomic groups. Symptoms and characteristics vary greatly in both type and severity. Depending on the diagnosis and treatment, treatment costs can be very high, with one study estimating the lifetime societal costs associated with autism at \$3.2 million per person with the condition, demonstrating the extensive behavioral therapy and ongoing care required.<sup>ii</sup>

Whether the rising prevalence of ASDs is due to a true increase in the numbers of people with this condition or due to growing awareness and diagnosis, the estimated 730,000 people in the United States ages 0 to 21 with ASD represent a substantial challenge for providers.<sup>iii</sup>

Compounding the sheer size issue, these individuals tend to require more intense services; the majority of young children with ASD served through Massachusetts early intervention providers receive between 5 and 10 hours of individual attention weekly.<sup>iv</sup>

*Impact on Human Services:* ASD cases are putting capacity stress on the provision and purchase of early intervention, early childhood, primary, and secondary educational services and long-term care services. States are facing a shortage of program staff trained to treat ASD-specific needs. Professional development and training, certification and specialized training are a rising need. The Massachusetts Department of Public Health has been a frontrunner in building the capacity of early intervention providers to meet the needs of the ASD 0 to 3 population.

Adults with ASD require additional assistance and approximately 70% of adults are unable to live independently. A portion of adults with ASD live with family members and approximately 32% live in residential care facilities.<sup>v</sup> There is a gap in the long-term services and supports for this population including a lack of clinical expertise in provider networks, geographic service availability, a shortage of ASD training infrastructures, and supports for transition-age youth and adults to avoid “slipping through the ASD care cracks.”<sup>vi</sup> The adult ASD population is in need of treatment programs that focus on improving their daily life skills, provide access to employment, and focus on mental health outcomes all while in the least restrictive environment. Foster homes, supervised group

living and other community-based models are a service need for adults with autism.

**Traumatic Brain Injury (TBI):** Ranging from mild to severe, Traumatic Brain Injury (TBI) is on the rise for all high-risk groups, which include athletes, persons with disabilities, and veterans. The growth of the elderly population discussed below augments the seriousness of the effect of increased TBI as adults aged 75 years and older have the highest rates of TBI-related hospitalization and death. Direct medical costs and indirect costs of TBI, such as lost productivity, totaled an estimated \$60 billion in the United States.<sup>vii</sup>

**Impact on Human Services:** In order to serve individuals with TBI, case management services that address the special nature of their injury are necessary. In a 2009 New Jersey study there were “large gaps in community support services; 60-85% of those who needed the following services did not receive them: education, employment assistance, respite, or training in money management, social skills or community skills services.”<sup>viii</sup>

**Veterans:** Today's veterans number nearly 24 million. Though that population is projected by the Department of Veterans Affairs to fall as the older generations pass away, those returning from engagements in Afghanistan and Iraq present escalating challenges of their own. As a group, the number of veterans with VA-rated service connected disabilities 50% or more disabling and those determined by the VA to be unemployable due to service-connected conditions has risen by 142% since 2000.<sup>ix</sup> Data like this supports the claim from the Department of Veterans Affairs that contemporary veterans are sustaining more intensive injuries that might well have been

fatal in earlier wars, increasing the cost of intensive medical care and associated services.<sup>x</sup>

As of July 2011, more than 2.2 million U.S. troops had served in the Iraq and Afghanistan wars.<sup>xi</sup> As these troops return home from their military engagements, many of them face ongoing battles with the lasting effects of their service, be they physical or psychological. In 2009, Department of Veterans Affairs reports showed that in the years since 9/11, an average of 258 new, first-time Iraq and Afghanistan war veterans had been treated daily at VA hospitals and clinics.<sup>xii</sup> Whether they seek treatment or not, nearly one in five service members returning from deployment are thought to have symptoms of post-traumatic stress disorder or major depression.<sup>xiii</sup> With the active conflicts in the Middle East, the number of disabled veterans has jumped by 25% since 2001 to 2.9 million.<sup>xiv</sup>

Interestingly, more veterans, particularly more young veterans, than expected have been seeking care from the public health care system.<sup>xv</sup> This suggests that veterans are more aware of the benefits available to them than they once were and that the military's campaign to reduce the stigma associated with seeking treatment has made an impact.

**Massachusetts had a total veteran population of about 393,700 in 2010.**

With the crest of demands on government services from Vietnam veterans still to come,<sup>xvi</sup> the growing pool of disabled and in-need veterans from our recent wars will strain existing service systems. Expenditures are projected to rise with an increase in the aging veteran population, the number of disabilities

claimed, and the severity of injuries sustained.<sup>xvii</sup>

*Impact on Human Services:* The rise in the high-needs veterans and aging disabled population will have an impact on both the state and federal services as they attempt to deal with the specialized services required to serve these individuals. Beyond their physical health needs, this population will require intense and specialized behavioral and mental health services. Mental health professionals with specific training and expertise are needed to serve these individuals in the areas where they reside. The long-term effects of TBI on veterans and how multiple deployments might impact domestic violence and mental health is currently unknown but there are potential service needs.<sup>xviii</sup>

*Elderly:* The 2010 Census found that the senior population is increasing faster than its younger counterparts.<sup>xix</sup> Between 2000 and 2010, the 45 to 64 population grew 31.5% to 81.5 million, and now makes up 26.4% of the total U.S. population. This rapid growth is due to aging of the Baby Boom generation; January 2011 ushered in the first of approximately 77 million Baby Boomers, born from 1946 through 1964, to turn 65.

***National average % of population age 65 and over: 13.0%***

***MA population age 65 and over: 13.8%***

As this generation surges toward retirement, there is a strong and present need to prepare for and meet the needs of our aging national population. For many, their increased life expectancies and energetic lifestyles will translate to a long and active retirement—

approximately 25% of their lives. Moreover, today's physically and intellectually active younger generations predict that tomorrow's elderly population will be better educated, healthier, culturally literate and, as individuals, more discerning consumers.<sup>xx</sup> This generation is also open to seeking assistance from services and is interested in areas that concern them.<sup>xxi</sup>

***Average annual cost of nursing home services: \$85,000 to \$120,000***

***Average annual cost of an in-home aide for 6 hours daily: \$40, 000***

*Impact on Human Services:* The impact on the costs of providing health care through Medicare and insurance programs are widely publicized. According to a 2010 Virginia Tech study, baby boomers are more likely to ask for assistance in the forms of service coordination, assessment and counseling.<sup>xxii</sup> This sector will also put stress on long-term care and consumer-directed services as people aim to stay in their homes longer. This preference for in-home care represents substantial cost savings; the average cost of a nursing home ranges from \$85,000 to \$120,000 a year, while hiring an aide to spend six hours a day on average in the home starts around \$40,000 a year.<sup>xxiii</sup> With these costs of care, the need for Long Term Services and Supports and home-care services will increase. This will also have an impact on case management services for the elderly population. They are more likely to request services such as home meal delivery or community meal sites.

Basic human services continue to be in great demand on a macro level. The dramatic

increase in foreclosures in the recent recession has left families particularly vulnerable to housing instability. Approximately 43% of families with children report that they are struggling to afford stable housing.<sup>xxiv</sup> Federal funding under ARRA has expired, so states would need to make these plans on their own accord.<sup>xxv</sup>

### ***Economic Strain***

The second major driver of change in the human services sector is the economic strain faced by state agencies. State tax collections are still roughly 9% below their pre-recession levels. At the same time, unemployment remains high.

Over the last four years, the unemployment rate has nearly doubled. Drastic growth in the number of unemployed began in 2008 and has remained steadily high since then at well over 9%. Massachusetts has consistently fared better than the nation overall, with the most recent published rate at 7.4%, still historically high. This population puts stress on job programs, emergency housing, food pantries, employment, workforce, mental health, and other services.

There have been sharp increases in public benefits such as the Supplemental Nutritional Assistance Program (SNAP) and the Children's Health Insurance Program (CHIP). Non-federal food assistance programs are seeing a rise in food needs from families. Emergency homeless prevention services are also on the rise. In the upcoming year, it is expected that states will struggle to support these services as ARRA funds expire.

In the large majority of proposed budgets for fiscal year 2012, governors set spending below 2008 levels (overall 9.4% below) adjusted for inflation, despite the growth in demand for services across education, health, and human services systems. With states reluctant to raise revenue through higher taxes and some even cutting taxes, the stress on states, their populations, and their providers remains high.<sup>xxvi</sup>

***The majority of governors' proposed budgets for FY 2012 set spending below 2008 levels.***

Fiscal year 2012 marks the fourth consecutive year of budget-cutting for states, and this latest round of cuts is substantial. As of June 27, 2011, 75% of states that had enacted their budget for the coming year included major cuts to important public services to close their respective budget shortfalls. The ramifications for human services are wide-sweeping for example:

- Cuts to child care budgets have been felt across the country. Arizona is canceling child care support for low-income families—denying 13,000 children assistance—and continuing a freeze on its primary children's health insurance program, for which about 60,000 children would be eligible. In Pennsylvania, due to budget cuts, parents have been asked to pay higher co-pays for service. New Mexico has created waiting lists for its child care subsidy program.
- States and localities have directly eliminated 535,000 jobs in education and other areas nation-wide, and that number does not include the cuts borne indirectly

by vendors and non-profits that rely on government funding.<sup>xxvii</sup>

Compounding this tight revenue picture, the federal stimulus dollars that had helped to stabilize state budgets and promote hiring in recent years have ended. Distributions of the \$814 billion in stimulus funding from the American Recovery and Reinvestment Act end September 30, 2011. To meet the ongoing needs of their populations, states must make choices about whether to pick up ARRA or other former federal expenditures on their own, such as in Rhode Island, which recently set aside funds to cover a heating assistance program expected to be cut from the federal budget.<sup>xxviii</sup> With no reprise of the Build America Bonds program launched in 2009 or the \$10 billion supplement to the State Fiscal Stabilization Fund in 2010, states face a collective shortfall of \$103 billion for FY 2012.<sup>xxix</sup>

With more program cuts underway and on the horizon, states are making difficult choices, and some are arriving at creative solutions. Economic limitations today go hand-in-hand with provider rate and capacity reductions, as well as a growing demand for accountability on the part of government, which in turn filters through to providers. Likewise, states are bringing new payers into the system in order to maintain service provision. Economic strain, then, encompasses more than just the states' balance sheets; it also manifests itself in the standards of what they require from state contractors and changing payment structures.

## Issue #1: Consumer-Centrism

### ***Defining Customer-Centrism***

Customer-centrism is part of the greater human services “culture change” toward person-centered care where state agencies are serving individuals in the least restrictive environment, shifting toward locally based services, and meeting the self-determined needs of individuals in ways that are convenient for them.<sup>xxx</sup> Overall, customer-centrism is a movement to meet people “where they are at” through both community-based and consumer-directed care models. With the alternative to remain in the community and receive personal care services in their home, customer-centric services offer more familiar, often more comfortable options for customers who might otherwise be served in a long-term facility.

In the realm of human services, customer-centrism prioritizes the ability of individuals to control their budgets and service options and especially to receive services in their homes rather than in institutional settings. This model also allows for people to pay for “non-traditional” services like shopping, cleaning, and household help, which in turn affects who providers are and can be. Providers under this model can include family members as well as non-credentialed staff who can address basic needs. The trend of increasingly customer-centric services brings with it higher expectations for customization, technology, and other provider challenges that will be discussed in more detail below.

At the 2010 Human Services Summit held at Harvard University in collaboration with the American Public Human Services Association, the importance of developing capacity to meet the needs of individuals was at the forefront. “Providing solutions that empower people to reach their fullest potential in an independent and sustainable way” served as a foundational tenet for the Summit overall.<sup>xxxi</sup> This emphasis is evident in the priorities of public agencies and providers across the country. For example, the Texas Health and Human Services System Strategic Plan for 2011-15 opens with priorities that include delivering the highest quality of customer service, which is defined as improving business processes to create a more coordinated, cost-effective, and customer-friendly service delivery system.<sup>xxxii</sup>

Centers for Medicare & Medicaid Services (CMS) is facilitating state decisions to increase the number of clients receiving home- and community-based services. The application process for §1915(c) waivers has been revised and now includes a web-based application and published, consistent review criteria. Educational materials and technical assistance outreach have been developed to help states implement §1915(i) waivers. There is also enhanced funding and technical assistance available through the Money Follows the Person grant program to reinforce and increase state efforts to serve clients with high-quality home- and community-based services.<sup>xxxiii</sup>

As this customer-centric philosophy of service has grown, so too have related expectations of

service providers. This trend is closely connected to the rise and spread of networks, mobile systems, and data-tracking technology, which have broadened channels of communication and enhanced data-collecting capacity.<sup>xxxiv</sup> Data-driven programs and outcomes reporting have come to dominate conversations about how to meet the “corporatized,” private-sector-influenced expectations of customers (as well as funders).<sup>xxxv</sup> Information-based programming and setting/achieving concrete goals are not new, but their growing emphasis is a step further down the road towards more rigorous strategic planning in the provider sector in order to meet the needs of customers and track their outcomes on a case-by-case basis.

### ***Towards Community-Based Care***

Over the past several decades, health care and human services alike have moved towards a deinstitutionalized model of community-based care. In the early 1980s hospitals were forced to begin thinking about shortening the lengths of stay for patients due to the introduction of the Diagnostic Related Groups for their inpatient Medicare consumers. As the industry and patients became accustomed to this trend and as the continued downward pressure on costs for providers and facilities became the norm, alternative care settings and community support networks became more established. The passage of the Olmstead Act reinforced the concept of allowing historically institutionalized individuals the option of moving from those institutions into the community where they could live and participate in programs that were seen as less restrictive and costly while adding to the quality of life for the individual. While

this was designed to address the more disabled population, it served as a mechanism to develop demand and interest in community-based care for a broader set of individuals.

The Olmstead-driven change in law, along with continued legal pressure,<sup>xxxvi</sup> forced states to reform their systems of care and to develop better community-based systems over a relatively short period of time. Though the transformation is not yet complete, the community-based model has grown and spread across the human services spectrum to include child welfare and juvenile justice agencies, as well as mental health and disability agencies.

The related rise of family members and other informal supporters as potential recipients of payments represents a major change in the provider landscape. The benefits to clients are clear; they receive care from a person with whom they are familiar and can create a more stable situation for themselves and their caregiver. Research has shown that the caregivers themselves need support, too, and that multi-component interventions in support of caregivers significantly reduced their burden.<sup>xxxvii</sup> Strengthening the competence and confidence of family and informal caregivers can not only reduce caregiver distress,<sup>xxxviii</sup> but also help them to meet the demands of the person for whom they are caring.<sup>xxxix</sup> Finding ways to support this familial/informal network of supporters is an opportunity for existing providers, who have expertise in high standards of care and coping strategies.

### ***Money Follows the Person***

Enacted into law in 2006 and extended with an additional appropriation of \$2.25 billion through 2016 via the Affordable Care Act (ACA),

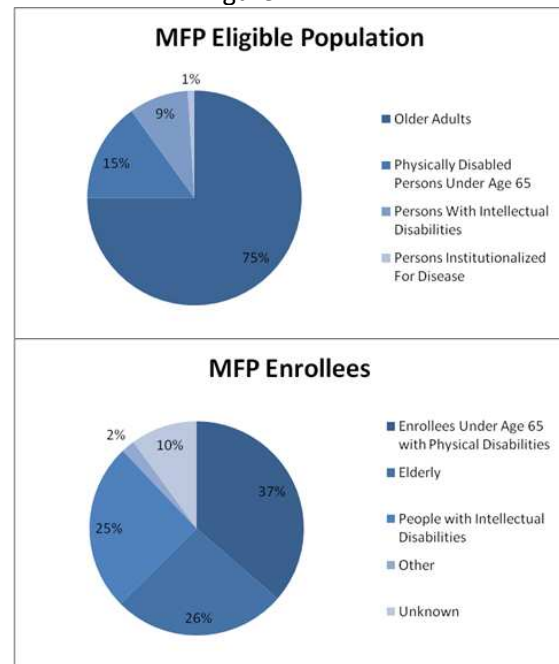
the Money Follows the Person (MFP) demonstration grant is a federally funded program that pays out subsidies to incentivize the transition of persons from institutions to community-based care. Specifically, MFP provides 12 months of federal matching funds for each Medicaid beneficiary moved from an institutional setting to a community-based one. The program serves five primary target populations: Elderly, Nonelderly with Disabilities, Participants with Intellectual Disabilities, Participants with Mental Illness, and Others (such as people with two or more primary diagnoses and those who do not fit into the other groups). To qualify, people must have lived in an institution for at least 90 days (down from six months prior to the ACA) and qualify for Medicaid.

**Massachusetts was one of 13 states to receive a Money Follows the Person grant in February 2011. Twenty-nine other states already had programs in place.**

Prior to the addition of 13 new state grantees (including Massachusetts) in February 2011,<sup>xi</sup> twenty-nine states and the District of Columbia had implemented MFP transition programs. When MFP implementations began in 2007, 75% of eligibles were older adults, 15% were physically disabled persons under age 65, 9% were persons with intellectual disabilities, and 1% were institutionalized for mental disease. This distribution is not mirrored in the picture of MFP enrollees, however. By the end of June 2010, 36% of enrollees were under age 65 with physical disabilities, 26% were elderly, 25% were people with intellectual disabilities, and the remainder other (2%) and unknown (10%). In short, as shown in Figure 1, there were

disproportionately more participants under age 65 with intellectual or physical disabilities than their representative percentage of the eligible population.<sup>xli</sup> The disproportionately high number of enrollees of working age (under 65) suggests that more employment-related community support services, including transportation, will likely be needed in the years to come.<sup>xlii</sup>

Figure 1



This grant program represents a major opportunity for human services providers that serve the MFP target populations. Participating states have identified a wide range of pre-transition services and approaches to target potential MFP participants and successfully transfer individuals back to the community. Common services include expanded case management to coordinate transition, help with home modifications and one-time housing expenses, use of assistive technology, transportation, and durable medical equipment.<sup>xliii</sup>



With MFP in place for five years now, some significant progress has been made towards deinstitutionalization, largely at a reduced cost. As of July 2010, nearly 9000 individuals had been transitioned back to the community, with another 4000 in progress. The majority of transitions were for persons with physical disabilities and seniors. According to a report from the Kaiser Family Foundation, most states (22) have said that MFP per capita transition costs were lower than the comparable institutional Medicaid cost for those beneficiaries. Comparisons to other Medicaid Home and Community-Based Services beneficiaries, however, were more varied; eight states reported lower per capita costs through MFP, seven said costs were comparable, and six said MFP costs were higher.<sup>xliv</sup>

Reported changes in participant experience through community living have been remarkably positive.<sup>xlv</sup> One year after transition to the community, MFP participants reported improvement in the quality of their lives across all domains considered, including Satisfaction with Life, Meeting of Personal Care Needs, Treatment by Providers, Satisfaction with Living Arrangements, and Community Integration. Notably, the greatest improvement was seen in Satisfaction with Living Arrangements, where satisfaction rose from 54% pre-transition to 94% post-transition. Among all participants dissatisfied with their institutional living situation, 92% were satisfied at one year post-transition. Across all target population participants, satisfaction with the way they lived their life increased by 35% post-transition. Even for participants with intellectual disabilities, who reported relatively high levels of life satisfaction (73%) before transition, there was a nearly 20% increase post-transition. MFP

participants also experienced a significant improvement in their treatment post-release; 92% of participants post-transition reported being treated with respect and dignity, compared to 67% pre-release. Importantly, reported physical abuse also decreased by 67%.

Several challenges have also been identified in the last five years of the MFP program. The Kaiser Family Foundation gathered information from the first round of awardees and found that the biggest challenge for states has been the lack of affordable, accessible housing. To address this barrier, 19 states have established partnerships with local public housing authorities, and six have employed housing coordinators.<sup>xlvi</sup>

*The biggest identified challenge for MFP programs has been the lack of affordable, accessible housing.*

Another major obstacle is the inadequate supply of direct-care workers in the community. To overcome this, states have implemented direct care service registries, provided online training programs, and enabled the hiring of family caregivers, in addition to more traditional efforts to promote stability through compensation and benefits.<sup>xlvii</sup> The development of the service registries directly impacts providers as it creates a new channel by which potential clients will find suitable matches for their needs, and it is in their interest to connect with them and maintain up-to-date listing information. Providers can also work with state agencies to understand their current needs, educate them about the unique services that they provide, and negotiate compensation and benefits packages that

promote the development of the workforce needed to serve the state's service populations.

*Under the ACA, the minimum period of institutionalization required for MFP eligibility will be just six months.*

*Projected annual increase in persons eligible due to this change: 12%*

There are also challenges to meet as the MFP target populations and the program itself change. States have voiced concern around the need for infrastructure investment to support the expansion of Home and Community-Based Services, specifically the community-level resources to support individuals with serious medical and long-term service needs. This is especially pressing since the eligible population is expected to rise in the years to come. The shorter period of institutionalization required for eligibility under the ACA will mean an increased number of eligibles across target populations; the annual increase has been estimated at 12%.<sup>xlviii</sup> Additionally, it was thought that the slow pace of economic growth could lead to a possible decline, either through reduced rates or reduction of services, in the number of community providers that allow for successful community transition.<sup>xlix</sup> Lastly, as of October 2010, the assessment for all nursing home residents has been revised to include a question that asks them if they want to talk to someone about returning to the community. If the nursing home does not have the resources to help a person move out, the home must provide a referral to a local contact agency, and this requirement will likely produce more referrals to the MFP program itself.<sup>l</sup>

Another possible challenge worth considering is the possibility that the disproportionately low representation of elderly enrollees from nursing homes may suggest a significant barrier to community living for that population. Beyond the intensive medical needs that may prevent an HCBS transition, states have identified the following possible explanations: insufficient affordable and accessible housing, insufficient community services for this population, and/or difficulty arranging family or other informal supports.<sup>li</sup> To facilitate these efforts, providers can prepare for the community-based needs of future persons in transition and reach out to local hubs of family and informal caregivers to find ways to support their activities.

As Massachusetts develops its MFP program, it is worth noting the many variables at play. Federal MFP rules give states the flexibility to target their MFP programs toward some or all of the five participant populations and to implement their programs as best meets their needs. Indeed, this flexibility may explain the above-mentioned discrepancy between the demographic distribution of eligibles and program enrollees.<sup>lii</sup> Across the original set of MFP awardees, just 47% of planned transitions were planned for the elderly, far fewer than the 75% of the total eligible population. Some states concentrated on only certain groups—Iowa, for example, serves only people with intellectual disabilities. On this front, states have been driven by individual agency priorities, existing waiver programs, and/or legal and political mandates.<sup>liii</sup> Through education about the populations they serve, providers can help to set those priorities.

Beyond the planning phase, each state must also execute its transition plans, and here again

there is much room for variability. Program outreach and cooperation on the part of institutions are both basic factors of on-the-ground implementation that can differ across target populations. The agencies that state Medicaid agencies are able to partner with when conducting initial eligibility assessments and program awareness can affect enrollment distribution, as can the existence of contracts or other strong relationships with third parties that serve one population or another. In Illinois, as an example, the state's mental health department has been very cooperative, resulting in a relatively high number of enrollees with mental illness. Educating and securing the buy-in of providers and case managers are both crucial to program success.

Finally, it is up to each state to solidify and develop partnerships, especially in the affordable and accessible housing and workforce arenas mentioned above, in order to secure successful transitions for eligible participants.<sup>liv</sup> As of June 2010, community living arrangements of participants include homes, apartments, assisted living facilities, and group homes, the prevalence of which varies by target population. For example, 47.7% of elderly participants lived at home and only 8.4% in a group home, but for participants with intellectual disabilities the situation is nearly reversed—just 3.0% at home and 75.0% in a group home.<sup>lv</sup> Providers can get ahead of the curve by establishing or growing their service offerings to support these transitions in the short- and long-term.

## ***HOME Choice: Ohio's Money Follows the Person Program<sup>lvi</sup>***

Ohio received \$100 million in enhanced federal matching funds in 2007 and has been identified as a leading example in this demonstration project.<sup>lvii</sup> Ohio aimed to use the MFP opportunity to balance its long-term services and support system, looking at the system as a whole, across disabilities. Ohio's program is managed by the state's Medicaid agency, the Department of Job and Family Services. Ten people work for the program, with specialists in outreach, enrollment, housing, population-specific community living administrators, data, and balancing long-term services and supports. HOME Choice is a "wrap-around" program to the existing state Medicaid program, meaning that participants enroll in one of the state's HCBS waivers or receive services through Medicaid, and HOME Choice services for the first 365 days assure continuity of care and integration into community living.

Ohio's experience highlights some interesting lessons learned about MFP:

- As was found in many states,<sup>lviii</sup> unexpected delays can limit the number of successful transitions during the early days of an MFP program. Ohio originally set its goal at transitioning 2,231 people by 2011, but only about 40% of those transitions were realized. IT and administrative issues caused a later start date than anticipated. Also there were fewer than expected transitions in the elderly due to the (now reduced) six-month institutional residency minimum.
- From the provider perspective, the program seems to work for those who are transitioned, but the lack of pervasive education to case managers and social workers has limited program penetration.<sup>lix</sup>
- Also from the provider perspective, the state's strategic focus can prove frustrating on the ground. For example, skilled nursing and intermittent care are covered, but personal care services are not, which keeps the program from reaching more potential clients.<sup>lx</sup>
- It is most expensive to transition individuals with developmental disabilities—an average of \$8,554, compared to \$4,519 for persons with physical disabilities and \$2,379 for seniors.
- The average length of time to complete a transition is about 134 days but can vary widely. Interestingly, though people with developmental disabilities are the most expensive to move, they can be the fastest to transition due to their support and advocacy systems.
- Most participants transition to apartments, but vouchers for apartments are hard to find, even with HOME Choice's housing specialist employed within the Medicaid agency. The biggest delays are felt by persons with mental health issues and those with physical disabilities. Continuing to identify appropriate and available housing remains a substantial challenge, especially as the eligible population grows.

*Why It Works:* The state's commitment to transitioning clients out of institutional care can be found at all levels, from individual providers up to high-level state administrators. With all stakeholders on board, efforts to educate staff members and train them as needed have met with little resistance, although more education is still needed. Beyond this philosophical alignment, one of the most crucial and distinctive factors in Ohio's success was the availability of housing slots at the program's outset.

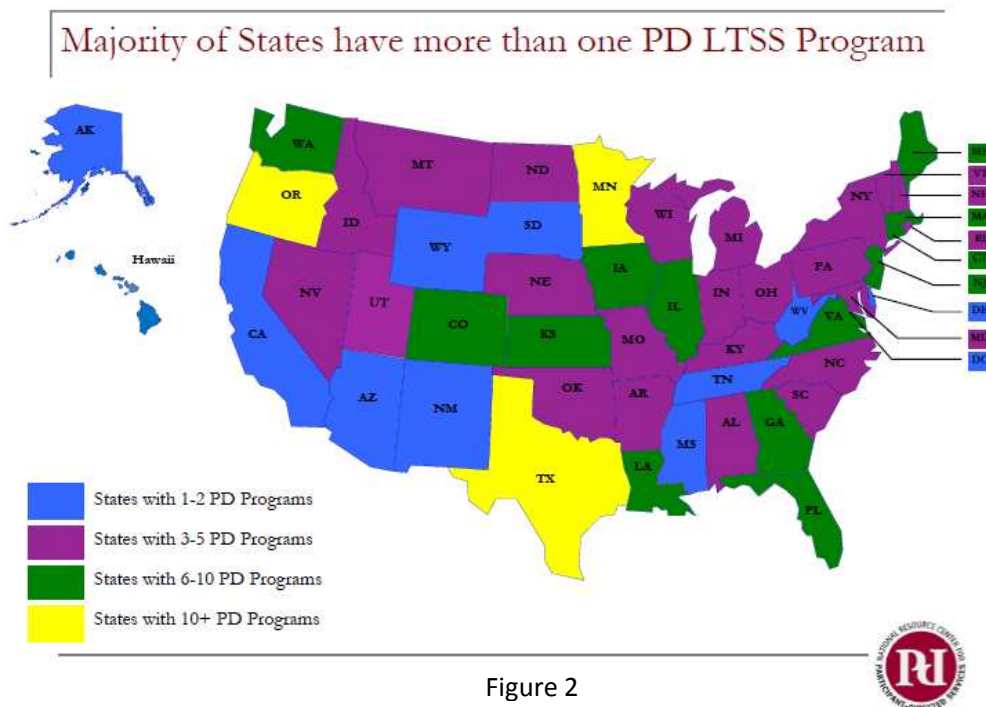
## Participant-Directed Services

Closely related to the rise of community-based care, there has also been a rise in participant-directed (PD) care, also known as consumer choice or consumer-directed care. In the late 1990s several pioneering states developed programs within State Medicaid plans to support consumer-directed care. Since 2000 these programs have grown dramatically and are seen increasingly as a standard program offering to individuals in publicly funded long-term services and support programs. At the same time there have been fundamental changes in federal law, regulations, and policy, which have reinforced the requirement to prioritize consumer choice when seeking support for community-based care as an

alternative to being placed in a health care facility.<sup>lxi</sup>

*Over 90% of people who have participated in the country's largest consumer-directed services program were satisfied and would recommend it to a friend.*

Out of the consumer-focused model has emerged the Participant-Directed Long Term Services and Supports (PD LTSS) program. Today every state has a PD LTSS program; the majority have more than one (Figure 2). The national average program size is approximately 1,100 enrollments, but the majority of programs have 500 or fewer participants, suggesting a market with a few very large players and many more smaller ones.

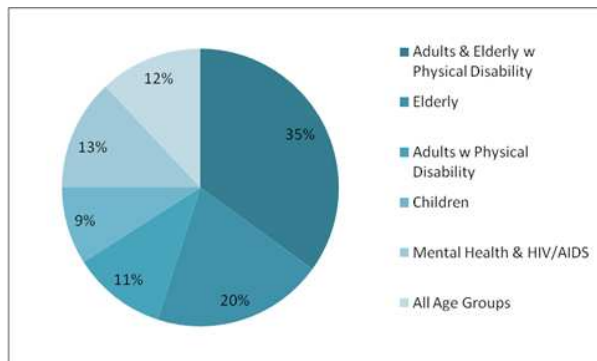


PD LTSS programs serve specialized wide variety of specialized groups, including adults and

elderly persons with physical disability, children, and mental health populations (Figure 3). Elders

and adults with physical disability represent 35% of LTSS participants, the elderly—20%, adults with physical disability—11%, mental health and HIV/AIDS—13%, children—9%, and programs with all age groups included—12%.

Figure 3: LTSS Participants



The consumer-directed services market has evolved to the point where it is routinely a basic offering in public sector health care programs. This model has been adopted and is used in Medicaid Home and Community Based waiver programs. The final main area of adoption has been for the Veterans Administration to support participant-directed services for disabled and aging veterans.

Application of these models varies by state but is typically set up where the state, if Medicaid-sponsored, sets pay rate guidelines, and then the employer and attendant negotiate a pay rate that fits these guidelines. Employment Agreements are established and various enrollment/employment documents are executed. This can include the use of a Fiscal Employer Agent that is designated by the State or other Agency to provide financial management services such as timesheet and payroll processing and tax management.

The focus and set of PD LTSS programs varies based on the policy and leadership focus in each state. Some programs support more of a medical model approach while others develop around a more social model. Both approaches saw slow development up through the 1990s, but in the 2000s this field grew dramatically. Where there were just 30 programs at the end of the 1990s, today there are approximately 240. Nationally there are approximately 747,000 participants, with California representing 65% of the enrollments. LTSS program costs nationally in the 2010-11 year reached an estimated \$7.7 billion.<sup>lxii</sup>

PD services programs provide a mechanism for the consumer who is most typically eligible to be placed in some long-term care facility the option to remain in the community and receive personal care services in the home from people whom they hire and pay with state appropriated funds. There are two principal models employed in these programs:

- *Employer Authority* – where the consumer hires personal care attendants whom they pay for the services provided based on a fee schedule that is developed by them or by the program. The majority of programs have requirements related to pay, payroll schedules, and hiring requirements for attendants such as criminal background checks, age restrictions, and who may be hired – many programs do not allow a spouse to be hired to be the attendant.
- *Budget Authority* – where the consumer receives a monthly budget that is managed by them and used to purchase goods and services within the limits of the budget and the identified program guidelines.



Every state in the country now has at least one Employer Authority option for participants to act on their own behalf as the employer making hiring decisions for personal care attendants to

provide services within their homes. The Budget Authority model, which allows for the purchase of both goods and services, is widespread as well, as shown in Figure 4.

Figure 4

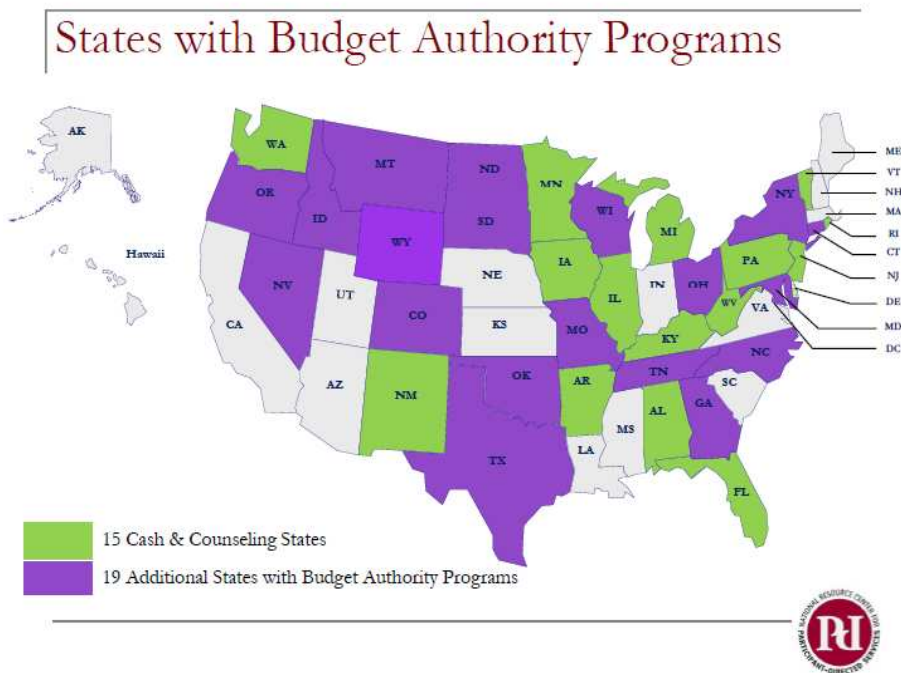
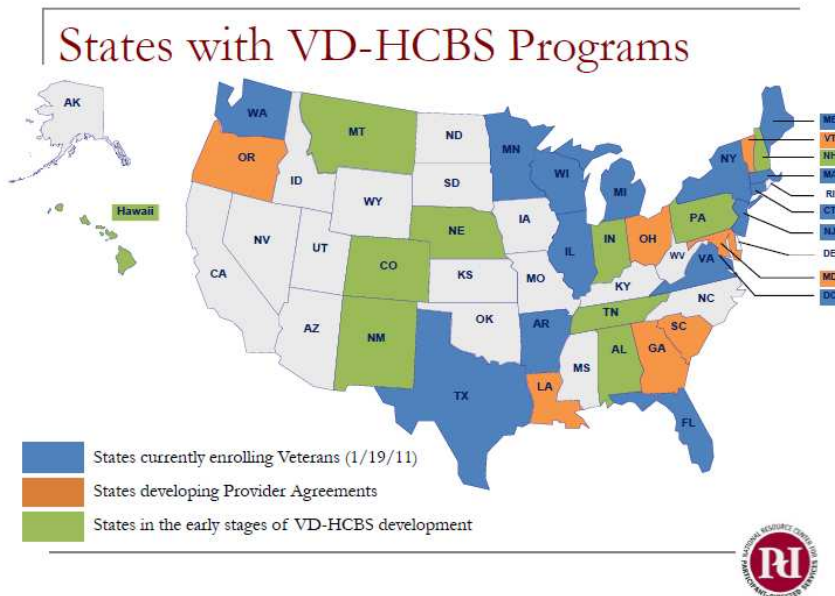


Figure 5



Mapped in Figure 5, the Veterans Directed Home and Community-Based Services program has similar features that include:

- Independent budgets
- Person-centered planning
- Spending plan including goods and services
- System of support – including Veteran Directed Counselor and Financial Management Services.

Each of the PD programs strives to incorporate consumer input and involvement. The methods of inclusion are individual interviews with participant and family, periodic surveys, focus groups, and advisory councils. This involvement helps the program stay focused on the needs of the consumer as they develop new programs and/or refine existing ones. The consumer choice model has been shown to yield very high satisfaction levels. In surveys of consumers who have participated in a consumer-directed services program the overwhelming sentiment (over 90%) is that they are satisfied with the program and would recommend it to family and friends.

The PD model continues to grow and expand within national publicly funded programs such as Medicaid and the Veterans Administration. The Affordable Care Act has promoted these services through funding for consumer-directed efforts such as the Community First Choice Option, which aims to make community living a first choice and leave institutional care as a fall-back option, and the Money Follows the Person grant program where an allocation budget is given to assist individuals to transition from institutions to the community, where they can take advantage of tailored services. The Money

Follows the Person grant and related lessons to date are discussed in more detail below.

### ***Arizona Long-Term Care System***

Arizona has one of the nation's leading Managed Care Long-Term Supports and Services programs, the Arizona Long-Term Care System (ALTCS), overseen by the Arizona Health Care Cost Containment System Administration. In addition to institutional, acute, and hospice care, ALTCS includes a wide range of home- and community-based services. Arizona has found that home- and community-based care brings a substantial savings: the average cost of these services to the state are \$1,635 per month, compared to \$5,418 for nursing facility care.<sup>lxiii</sup>

From the provider perspective, it is important to be cautious about pushing the envelope too far in terms of what non-institutional care can handle. Though insurance companies and families may each for their own reasons want people to be served in home- or community-based settings, that may not always be appropriate. As persons with more acute conditions are sent to assisted living, it is an ongoing challenge to find the right fit in terms of skilled personnel and patient oversight.<sup>lxiv</sup>

The relatively low rates set through ALTCS have helped the state to realize savings and been manageable for providers thus far. However, lowering rates too much could have a negative impact system-wide if lower-cost non-institutional providers are discouraged from accepting ALTCS clients.

*Why It Works:* Arizona has the nation's oldest capitated long-term care Medicaid program, and stakeholders have grown accustomed to the managed care system.<sup>lxv</sup> Providers contract with state-contracted health insurers, which allows flexibility and specialization through negotiation.<sup>lxvi</sup> Also, ALTCS' philosophy resonates with its target population as it promotes the values of choice and dignity.<sup>lxvii</sup>



### ***Keys to Success and Related Challenges***

Drawing from active programs in Arizona, Hawaii, Tennessee, Texas, and Wisconsin, the Center for Health Care Strategies has studied and identified leading practices for Long-Term Supports and Services programs:

- Communicate a clear vision to promote program goals.
- Engage stakeholders to achieve buy-in and foster smooth program implementation.
- Use a uniform assessment tool to ensure consistent access to necessary services.
- Structure benefits to appropriately incentivize the right care in the right setting at the right time.
- Include attendant care and/or paid family caregivers in the benefit package.
- Ensure program design addresses the varied needs of beneficiaries.
- Recognize that moving to risk-based managed care is a fundamental shift for LTSS financing.
- Develop financial incentives to influence behavior and achieve program goals.
- Establish robust contractor oversight and monitoring requirements.
- Employ LTSS-focused measures for performance measurement.

From the provider perspective, success in a participant-directed LTSS model will require new ways of thinking about and engaging with the market. This type of service delivery model is predicated upon the shift of control to the participants and in some cases to umbrella agencies, which means the hiring decisions are decentralized and displaced from state agencies. Providers need to be able to articulate clearly their services and demonstrate the high

quality of their offerings in order to attract clients. They must also stay abreast of any changes in intermediary vendors and connect up with new payment systems.

The individualism of the customer-centric approach creates other categories of challenges for providers and states as well: meeting customer expectations, efficiency, demonstrable performance, affordability, and quality control. With the specialized needs of growth populations, ensuring that providers can respond adequately to customer demands is in and of itself a multi-faceted challenge, especially with the growth of the high-needs ASD, TBI, veterans, and elderly populations discussed above.

When a state is considering the implementation of a participant-directed services program, there are a number of things that need to be considered. The key areas are as follows:

- Implementation of an appropriate service model.
- Inclusion or exclusion of goods in addition to services.
- Establishment of payment structure between the participant and the attendant.

When determining an appropriate service model, the primary consideration is whether an ***independent contractor model*** or an ***agency services model*** would be a better fit.

Each of these two options lends itself to a different type of participant, and often both are implemented through the same program for different populations. The former requires more participation from the client in the selection of providers and can involve an

existing informal support network through the certification of familial caregivers. The client who is more interested in exercising control over the process and has an existing network of support makes a good candidate for this hands-on, independent contractor model. An agency services model, also known as an agency of choice model, is still a participant-directed model, but some of the hiring and other HR functions are centralized, which can lighten the load of responsibility on the client. A client who is not as capable or interested in having control over the hiring process and the people who will provide support in the home may be a better candidate for the agency of choice model. The majority of programs that have been implemented have both types of participants and therefore choose to have both models available. For providers, the agency services model maintains a more centralized point of entry, but it also makes providers more dependent on the relationship with the overseeing agency.

Programs must also delineate their scope of offerings, which may include **services only**, follow a **budget-based** model, or combine the two, again depending on the populations served. A budget-based model allows participants to exert control over their entire budget, including goods as well as services. The structure of the guiding waivers and/or that of the program itself may dictate the limits of participant-directed care in a given state or for a particular population. If the program focuses on participants transitioning from a facility-based care model to a community-based setting, there may be a need to support the purchase of goods to facilitate this transition. The decision to allow participants more total control over their expenditures for services and

goods based on an established budget is in large part a matter of programmatic and administrative philosophy. As programs mature the budget-based model appears to be adopted more readily. Participants in control of their entire budget have demonstrated that they use what they need and do not overspend or abuse the process. This model lends itself to the more capable participant that is interested in exercising control over their services. Providers who provide both goods and services would benefit from the additional payment opportunities available in a budget-based model.

The payment structure for participant-directed services can take the form of **set pay rates**, **rate bands**, or **negotiated rates between the participant and the attendant**. The payment structure is usually determined by the sponsoring program and its need for budget control. In Medicaid, where programs have restrictive budgets, rates for services by attendants are typically set. Veterans programs typically provide for negotiated rates between the participant and their attendants with limits on how low and high that rate can go. Greater flexibility in rate-setting can be especially appropriate if the program has chosen to engage a Fiscal/Employer Agent to support the program, because those management systems generally require flexibility to support open-ended and changing service scenarios. Regardless of the payment structure, it is important that rates set actually cover the cost of care and services delivered. Case-by-case negotiated pay rates represent the most potential volatility for providers, who would feel the burden from the need to devote scarce administrative resources to the rate-setting process.

## **Issue #2: Decentralization of Services and the Rise of Coordinating Bodies**

Over the last decade, the human services industry has seen the creation of coordinating bodies, distinct from purchasing agencies, charged with the management of increasingly localized services. Because state agencies often do not have the resources to provide the broad range of the individualized, local services now in demand or the manpower for the collaboration required for coordinated care, they are moving into the business of buying and managing services provided by others.

In certain areas of human services, especially participant-directed services, there is a movement to a managed-care coordination model. This model aims to coordinate care for people with multiple health and social needs. In the case of Virginia, for example, the state is struggling with how to move specialized populations into managed care and away from fee-for-service.<sup>lxviii</sup> Such a framework requires extensive cross-collaboration in the delivery and coordination of services across health care and other community organizations.<sup>lxix</sup> States are turning to coordinating bodies to provide oversight; these bodies include Child Welfare Lead Agencies, Early Intervention Local Interagency Coordinating Councils, Fiscal Intermediaries, and Accountable Care Organizations.

At a high level, this move towards coordinating agencies has several ramifications for providers. In some of these models—lead agencies and coordinating councils especially—providers can serve as or actively participate in the

coordinating body. This represents an opportunity, especially for large providers with substantial reach and organizational capacity, to become more involved in the administration and strategic development of their sector(s). These models also change the key points of contact for providers; where they once might have dealt directly with a state agency, they must instead (or at least in addition) build relationships with the coordinating bodies. There are and will continue to be new payment channels to establish, rates to set, and scopes of service to determine. In short, these coordinating entities may help to streamline things from the state perspective, but they present substantial operational challenges for providers, who must become familiar with a new administrative landscape.

### ***Child Welfare Lead Agencies***

Nationally the number of children served by child welfare agencies declined from 800,000 in FY 2002 to 662,000 in FY 2010, a 17% reduction.<sup>lxx</sup> The system has largely shifted from out-of-home placements to in-home support and stabilization services for at-risk families and children. The need to coordinate these services at a local level has resulted in the creation of coordinating agencies, or lead agencies, that are responsible for developing provider networks and managing cases and services at a local level.

The lead agency or case management agency is not a new structure in child welfare, but there is a rise in the use of these entities to coordinate localized services. They are part of a larger effort to privatize child welfare services. In this instance “privatization” takes the form of contracting out the case management function with the result that contractors make day-to-day decisions regarding a child and family’s case. The state agency and court review and approve decisions at periodic intervals or key points.<sup>lxxi</sup>

The lead agency model is also expanding into other areas of human services. In New Mexico, for example, the state built upon the early success of its Low-Income Housing Tax Credit program, which funds the construction of affordable new housing and the rehabilitation of existing rental units for low-income households, and established a local lead agency structure.<sup>lxxii</sup> The State identified agencies that would ensure appropriate referrals and secure commitments from community-based service organizations. This model builds upon a similar model in North Carolina, where 22 local lead

agencies designated by the state coordinate the delivery of supportive services for those in need of permanent supportive housing.<sup>lxxiii</sup> Post-Katrina Louisiana has also moved in this direction; six local lead agencies are designated by the Department of Health and Hospitals to refer eligible households and ensure supportive services are available as needed.<sup>lxxiv</sup>

*The Patrick-Murray Administration has awarded \$4.3 million in grants for local teen parenting programs that will make use of the lead agency model.*

States vary in the level of involvement the private contractors have. In some cases, the child might have both a private provider case manager and a state case manager. In other states, the child meets specific criteria and is managed by the private case management agency. In both forms, privatization creates a public-private partnership to deliver services.

Across the country, lead agencies have taken on various structures:

Lead Agency Type	Structure	Example
Statewide	Statewide privatization through case management agencies.	Florida Community-Based Care
Regional	Some regions privatized.	Texas pilot program Philadelphia County
Public-Private Hybrid	Some cases contracted out to help manage staff-to-caseload ratios and keep up accreditations standards.	Missouri Children’s Division
Target Populations or Services	Privatize the case management of specific services, or for certain populations.	Indiana Department of Child Services (high-needs children) North Carolina Division of Social Services (adoption)

Looking at the child welfare field, where lead agencies are most fully developed, states have adopted the lead agency model in various forms. In 2008 Rhode Island Department of Children, Youth and Families created an *integrated system of care* to provide wraparound services such as engagement, evaluation, planning, care coordination, and brokering for children in their care. The objective was to reduce out-of-home placements and reduce the use of residential placement but retained state involvement in the provision of child welfare services.<sup>lxxv</sup>

By contrast, Texas underwent a foster care redesign in 2010, and its system, currently in the procurement stage, transfers the case management, placement decisions and service coordination to a Single Source Continuum Contractor (SSCC).<sup>lxxvi</sup> The SSCC model hands over a majority of responsibility to the SSCC, *largely removing the state's involvement in the placement and case management of children*. Texas also implemented a blended per diem payment model—a blended rate per child per day regardless of placement. The provider must manage the services and caseload to provider services under the blended rate.

Interest in the lead agency model continues, but its growth is not a foregone conclusion. Most recently, the State of Washington released a procurement for lead agency entities to provide an integrated system of services and use a wraparound approach.<sup>lxxvii</sup> The associated RFP was formally withdrawn on May 26, 2011 due to legal actions against the state. Public agency workers sued the state to block its privatization efforts.<sup>lxxviii</sup>

There are several benefits of lead agencies. The lead agency model allows private providers

greater flexibility with how funds are expended to support children and families. Private entities are able to avoid the procurement requirements of the state and are often to contract for services much faster than a state entity. In addition, private non-profits are able to seek alternative funding such as private donations and foundation grants, which can supplement and expand services while building stability through a diversified funding base.

One of the main challenges with lead agencies lies in their administration. While experiences differ across states, a fully privatized lead agency model requires greater coordination at the local level of provider procurement, rate setting, contract oversight, utilization management, and training. In order to administer the contracts, child welfare agencies are creating more capacity around contract management, quality assurance and auditing to confirm that private providers are adhering to contract requirements. Non-profit agencies can also step up to oversee these functions and in doing so build a network of service providers.

Regardless of the payment type, the lead agency model pushes the risk to the provider to manage expenditures and their caseload. Providers have to provide services and meet specific outcomes within a limited amount of funding, which often does not increase over the contract duration. Changes in caseload numbers and severity of cases can have a serious impact on lead agency providers. Even with this shift of risk, or perhaps because of it, it is important for states to establish and maintain strong oversight to ensure proper management and service delivery in line with state goals.

## Lead Agency Examples

### *Missouri Children's Division*

The Missouri Children's Division was one of the early adopters of the lead agency model and created lead agency entities for foster care case management. The distinctive feature of this model is its clear alignment with the state's goal to reduce the caseload per staff ratio of its own workers. This goal was part of the state child welfare agency's division to become a fully accredited child welfare system. Rather than use privatization to shift all services out of the state's hands, Missouri supplemented its public agency's work with private staff to assist in reducing caseloads. Within three years, caseloads were successfully reduced without the loss of public or private staff.

*Why It Works:* Missouri had a clear vision and measurable goal, tied to accreditation standards, which helped the state know how much privatizing was really called for in their case.

### *Florida Department of Children and Families (DCF)*

Florida's DCF has fully privatized service coordination and delivery services. Privatization was the legislative solution to address statewide, systemic problems in the public child welfare system in Florida. Florida invited providers to propose a service delivery structure for geographic regions across the state. The lead agencies differ in how case management services are delivered and how services are funded and at what level. Community Based Care agencies (CBCs) are required to create their own provider network for all services. DCF deals just with the CBCs while the CBCs deal with the various subcontractors for services, including out of home, in home, case management, adoption services, independent living, among others. While both the CBC and DCF are the first to acknowledge that privatization has not cost less, but it has resulted in better outcomes.

Florida's current CBCs did not exist prior to the state's privatization. These entities arose as a result of the opportunity posed by the changes and to avoid competition among already-existing providers.

*Why It Works:* DCF committed to moving services to the CBC within a set timeframe and met that commitment. The public-private partnership here is especially strong – CBC and DCF work closely together to provide quality services. They also worked together to build risk mitigation into the governing legislation. Originally CBCs were required to return unexpended funds at the end of the fiscal year, but CBCs lobbied for a rollover allowance for general revenue, creating a safety net to account for changes in service demands. Finally, the state allowed enough time for the partnership and its services to develop organically; structures were not hurriedly put in place, and organizations had time to adjust to their expanding roles.

### *Nebraska Division of Children and Family Services (DCFS)*

In 2009, Nebraska's DCFS contracted with non-profit entities to implement a sweeping child welfare reform initiative, which moved community-based foster care and prevention service management to lead agency entities. Five non-profits across the state were selected. The state auditor recently completed an audit and found that state spending on child welfare services increased 27% since 2009. The auditor also found that the state failed to publicly bid multi-million dollar contracts with private service providers and spent thousands of dollars on duplicate claims and erroneous payments. Since 2009, three of the five providers have dropped or lost their contracts as caseloads and costs grew to unsustainable levels. DCFS and the state legislature are now debating how to best restructure the delivery of foster care services.

*What Went Wrong:* Deficiencies in DCFS' internal controls over financial reporting and operations have been identified as the causes for the auditor's findings, especially the duplicative payments and lack of contract reconciliation. It's too early to tell what additional issues impacted the model.

### ***Early Intervention Local Interagency Coordinating Councils (LICCs)***

As in other areas of human services, the field of Early Intervention Services has seen the rise of decentralized service planning and service implementation over the last several years. The Individuals with Disabilities Education Act (IDEA) requires that each state establish a state Interagency Coordinating Council, appointed by the governor, for the purpose of advising and assisting the State agency in the implementation of the IDEA Part C program, the part of the Act that governs Early Intervention services. The membership of the Council is specified in statute and regulations. Membership includes at least 20% parents of children with disabilities emphasizing the importance of family involvement in policy and program development.

In Massachusetts, the state's Council is strong. In most other states, there is a heavy emphasis on regional planning and coordination. Greater collaboration between service providers within counties or sub-county areas within larger municipalities facilitate joint projects and build organizational capacity among providers. These networks in Early Intervention are often referred to as Local Interagency Coordinating Councils (LICCs). LICCs facilitate information sharing, joint planning and coordination among clients, municipalities, community partners and providers. Much of their work is accomplished in standing committees and ad hoc task forces, who conduct long-range planning, study specific issues, and take appropriate actions.

At both the state and local level, these Councils are relevant to providers because they play a big role in shaping the strategic vision for Early Intervention service offerings. Building

relationships with Council members and understanding state and local priorities can help providers to stay ahead of the curve and meet the needs of their clients. Through their own advocacy, providers can also influence that shape of Early Intervention strategy.

Each Council functions as a planning body at the systems level and advocates for children from birth to three years of age and their families with or at risk for a developmental disability. The Council acts in three major roles: Advisor, Negotiator, and Capacity Builder.

(1) ADVISOR: Providing advice to the Local Community, Lead Agency, Governor and the state legislature on issues related to the development of a coordinated system of early intervention services for children with or at-risk for a developmental disability and their families.

The federal law defines the Council membership and the program in order to give it a unique view of the "service systems".

The parent component of the Council gives it a perspective which may be different from that presented by state agencies which are represented on the Council.

The Council can use its special vantage point to be recognized as a source of information for Local Communities, the Lead Agency, Governor, and legislators, as well as other key decision makers in the state.

(2) NEGOTIATOR: Working as an advocate to encourage a particular course of action by the state funded services.

A major activity of the Council is to "review and comment on the annual state plan for services

for children birth to three years" as part of its overall responsibility to assess the service system as it exists in the state. This information as well as interagency coordination is another important goal of the program and puts the Council in a position to be effective in making changes in how services are provided in the state. With agency and provider representatives on the Council, communication can more easily be effected and gaps between agencies can hopefully be bridged.

(3) CAPACITY BUILDER/SERVICE DELIVERY: Enhancing the ability of the overall service system to address service needs.

In this role, the Council works to increase the quality and quantity of desired supports and services from the public and private sectors, to ensure that all needy children and families will be provided early intervention services.

Additionally, in many states the LICCs are the administrative fiscal agent charged with developing local provider agreements and determining which community agency receives funding. In this manner the LICC serves as the local lead entity for the implementation of service delivery.

The National Early Childhood Technical Assistance Center (NECTAC) has identified four essential elements of high-performing IDEA Part C systems, of which ICCs are a part. Those elements are:

- Reliable and current data for decision making
- Monitoring and accountability
- Adequate numbers of qualified personnel

- Strong leadership, administrative support, and partnerships between state and local levels.

All of these pertain to state and local ICCs, especially the fourth, with its emphasis on a strong governing, management, and network structure. As NECTAC notes, consistency in leadership and support (including fiscal support) is always desirable but not always attainable. In this light, the relationship with a multidisciplinary agency like the LICCs then becomes even more valuable for providers and important to the success of the overall system.

The decentralization in the Early Intervention field and the accompanying rise of LICCs have brought some significant enhancements to the field. The decentralized system offers opportunities for creativity and responsiveness on the ground, which allows service populations to get the services they need. As multidisciplinary bodies, the LICCs bring together consumer, clinical, political, and administrative personnel at the community level. This merging of a variety of community members and stakeholders facilitates the building of bridges between involved agencies. In addition, these committees help to create and maintain a high-level vision of the service system based upon the participation and contributions of all relevant providers and consumers.

Decentralized services have some drawbacks as well. They can result in uneven capacity for service delivery among communities, and unequal access to services for residents. Also, they are fragmented, can be difficult to manage, and pose an especial challenge when it comes to strategic planning at the state or even regional level. They require (as legislators



recognized back in 1986 with the federal law that created Interagency Coordinating Councils), that a mechanism for leadership familiar with early childhood service delivery systems was crucial to their successful development. The LICCs represent an attempt on the part of Early Intervention Services Systems to capitalize on the advantages of the decentralized system and to mitigate the potential negative aspects.

### ***Social Innovation Fund***

Even in the federal grant funding stream, there is evidence of the move towards coordinated administration. In 2010, the Corporation for National and Community Service (CNCS, the federal agency that leads the Obama Administration's national call to service efforts) released its first solicitation for the Social Innovation Fund.

In the language of the CNCS website, this fund "is itself innovative and truly represents a 'new way of doing business for the federal government.'" Its key development is a reliance on outstanding grant-making intermediaries to select high-impact awardees who in turn sub-contract out, building up community organizations rather than government systems and infrastructure. The Social Innovation Fund also requires that each federal dollar be matched 1:1 by the grantees and again by their sub-grantees, thereby increasing the impact of federal dollars spent but also raising the fundraising stakes for recipients and associated providers.

### ***Fiscal Intermediaries for Participant-Directed Services***

As discussed above, the growth of Participant-Directed (PD) services and Long-Term Supports and Services has been substantial over the last decade. In synch with this pattern, states have employed a Fiscal/Employer Agent (F/EA), typically a private company, to provide financial management services for these programs. The F/EAs oversee financial operations, payroll, and tax functions, and they may also provide information management systems. This model requires the state to contract with a separate entity that has been authorized by the IRS to serve in this role and provides the consumer with a further option to become the employer and make more decisions related to the hiring of staff and the control over services being provided.

As the consumer-directed services option has evolved a fiscal intermediary model has arisen along with it. As of spring 2011, 39 states were reported to have an F/EA, and another was moving towards one. Twenty-one states have both an F/EA and an Agency with Choice, which serves as a primary employer of workers who provide services to the consumer.<sup>lxxix</sup>

The pressures for F/EAs to perform well, especially for CMS-related programs, are high. The Social Security Act established the mandatory timeliness of requirements for Medicare claims payment to providers of services, which means the F/EAs are required to pay 95% of clean electronic media bills between 14 and 30 days from the date of receipt, all while deterring fraud and abuse. Medicare contractors have been able to exceed their timely claims target through continuous refinement of their processes and the

standardization of processing systems.<sup>lxxx</sup> Strong F/EAs must have in place an administrative and HR structure that enables them to move funds, facilitate services, and assure quality so that their clients can receive the services they need in a timely and secure fashion.

There are several advantages of an F/EA structure. Vendor F/EA procurements and contracts allow states to engage specialized, who have the knowledge, experience, resources, and infrastructure necessary to provide effective financial management services, and to set cost-effective fees for F/EA services rendered, rather than providing these services in-house. Vendors under these arrangements may work either through a contract arrangement or as qualified Medicaid service providers. Either way, from the provider perspective, there are dedicated staff responsible for the coordination and management of reimbursement, which can streamline payments.

This structure also introduces some uncertainty for providers. Securing the business available through F/EAs can be more challenging than working with a centralized state agency. Since states are likely to be looking to cut costs through the use of the F/EA vendors, providers can expect to have to reset rates. Because states can use this system to provide freedom of choice of provider to participants, it can be challenging to navigate the system, especially for smaller providers who may be unfamiliar with this structure altogether. New relationships must be built, and there is also a growing role for direct outreach to clients.

Implementing a Vendor F/EA may present a number of challenges for government and provider program staff. In order to select or

serve as vendor entities and effectively monitor the quality of their performance, program staff must have adequate knowledge of federal, state, and local (as applicable) tax policies, procedures, and forms as they relate to household employers, domestic service workers, and Vendor F/EAs. They must also understand F/EA operations, often new terrain for both states and providers. In addition, the IRS staff knowledge of IRS policies and procedures related to Vendor F/EAs varies, sometimes resulting in incomplete and/or inconsistent guidance.<sup>lxxxi</sup>

### **Accountable Care Organizations**

The Affordable Care Act (ACA) creates coordinating agencies called Accountable Care Organizations (ACO). ACOs are provider-led organizations whose mission is to manage patients' full continuum of care and be accountable for the overall costs and quality of care for a defined population.<sup>lxxxii</sup> While this definition sounds similar to that of a managed

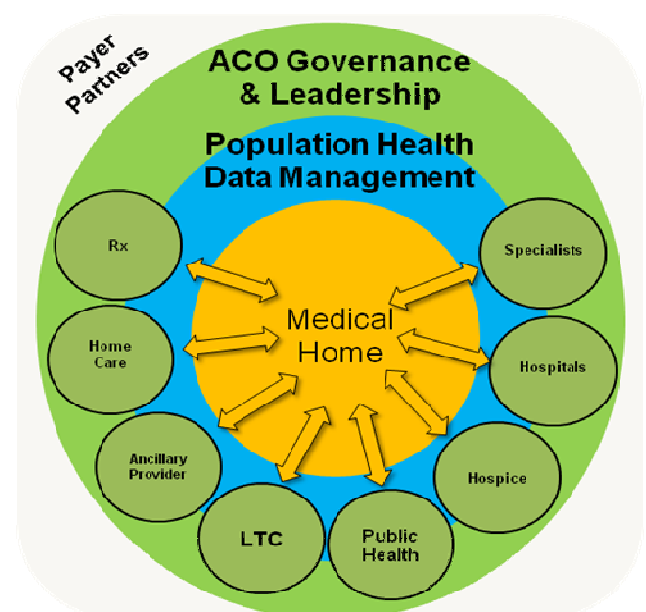


Figure 6

care organization (MCO) there are some key differences: ACOs are intended to serve the role of coordinating care and managing fee-for-service and shared savings incentives within a provider network. Variations of ACOs exist in the commercial, Medicare, and Medicaid environments, but the ACA provides an opportunity for health care organizations to get involved in the business of managing costs and care.

As shown in Figure 6, ACOs can contain a range of provider organizations, including:

- Primary care medical groups;
- Independent practice association;
- Multi-specialty physician group practices;
- Hospital-based systems with aligned practices; and,
- Integrated delivery systems (i.e., a network of health care providers and organizations that provide or arrange to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served.<sup>lxxxiii</sup>

Key attributes of an ACO include:

- Patient centered
- Medical home
- Continuum of care
- Population health management
- ACO governance and leadership
- Payer partnerships.

To many this definition sounds quite similar to an HMO or managed care, and that is not entirely incorrect. The major difference is that an ACO is provider-led, but the goals of care coordination are the same. What ACOs will

ultimately look like and how they will impact the provider and customer communities remain to be determined, but it is useful to understand how and why they are designed the way they are.

To put the potential benefits and drawbacks of ACOs into perspective, it is important to remember that the current health care system is dominated by a fee-for-service (FFS) reimbursement model. This model encourages the provision of more services (and more expensive services) and all but ignores quality outcome measures. Also FFS payment systems emphasize the provision of services by individual providers, rather than through coordinated teams that work across providers and settings that address the patients' needs.

According to numerous studies and pilot programs, coordinated care has the potential to eliminate waste, reduce medical errors, and improve outcomes at a lower total cost of care. Accountable care is designed to be a new delivery system that produces efficient and effective care through partnerships of all key players in local markets. The advantages are clear: Networks of providers will coordinate the care of services for patients, taking decision-making away from insurance companies and giving it to the providers themselves.

For both states and providers, ACOs bring with them a lot of uncertainty. At the core of this uncertainty are two significant system changes—new avenues of coordination between different providers and reimbursement based on clinical and financial outcomes. As such, it is incumbent upon social services providers to prepare for ACOs in line with the following recommendations:

***Agencies will need to consider partnerships with emerging ACOs and/or relationships with other providers.*** It is important for provider organizations to partner with ACOs as they develop. ACOs will be looking to provide a full continuum of care, a range of health care and, ideally, non-health care services to those assigned to the ACOs. As states look for entities that can provide and manage the best and most efficient suite of services, how providers fit into that continuum will determine their role under this new model.

***Outcomes measurement will be crucial.*** Payment for health care services will increasingly become tied to outcomes. This outcomes measurement will mean that agencies and providers will need to be able to communicate cleanly and clearly in order to measure and report outcomes accurately. The more a provider is able to “tell a story” about the quality of services provided, the more likely an ACO or other coordinated network of providers, will want that provider as part of their network.

***Risk in payment structures will change.*** Payment structures will be discussed in more detail below, but it is worth noting that while fee-for-service may still remain a form of payment from an ACO to some providers for some services, it is more likely that providers will be paid in more of a capitated fashion. It is important that providers and states understand the risks involved and the importance of fair and workable rate negotiations so that providers can provide the care that their customers need. At the same time, note that payments will also likely be tied to quality outcomes as well.

On the ground ACOs are still in the early stages of development. Versions have been piloted across the country, and they are heralded as a promising component of cost containment and health care reform. In Illinois, approximately 3,500 physicians within Advocate Health Care have signed an “ACO contract” with the state’s largest insurer, Blue Cross/Blue Shield.

Examples of how these organizations might work can be found in commercial insurance and Medicare. One forerunner was the Integrated Delivery System model, piloted by organizations like Geisinger and Kaiser Permanente. In these systems, hospitals form linkages with other health care entities such as physicians, insurers, and providers. They prioritize quality improvement, cost reduction, community health, and consumer responsiveness across a seamless continuum of care.<sup>lxxxiv</sup> In the world of Medicare, the Medicare Physician Group Practice Demonstration Programs (mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000) tested a hybrid payment methodology that combined Medicare fee-for-service payments with a bonus shared savings program. Implemented in 2005, these programs resulted in improved outcome measures and savings, and they provided the basis for the Medicare Share Savings Program in the Affordable Care Act.

A carefully modeled pilot in Vermont has yielded some early key findings about putting the ACO model into practice. The first takeaway is that any ACO cannot exist in a vacuum. It was found to be essential to enhance associated capabilities in primary care practice, community health systems, and state structures. **Five key**

capabilities for healthy ACO development were also identified:

- Ability to manage settings across the full continuum of care
- Financial integration with commercial and public payers
- A health information technology platform that connects providers along with a financial database and reporting platform for budget management
- Provider leadership and commitment
- Strong process improvement capacity.<sup>lxxxv</sup>

### ***Keys to Success and Related Challenges***

The types of coordinating agencies and related fields that have been **discussed in this section cover a wide range of** populations and services, but they share some common ground in terms of what makes them successful and what challenges they present for states and providers.

By nature, the coordination of decentralized services must weigh the benefits of regional, local, or even familial knowledge of client needs with the drawbacks of managerial complexity and potential for variations in care. Because coordinating agencies must work together with smaller entities as well as the state agencies, **organizational alignment** is especially important. Laying out clear goals for the coordinating body, defining its scope and charter, and establishing protocols all help to concretize the tasks at hand.

As with any management structure, **understanding the ground-level impact of any high-level changes** helps to ensure that the providers coordinated under the greater body are able to put into action any strategic plans

### ***A Promising Integrated Health Care Pilot***<sup>lxxxvi</sup>

In California, CalPERS (the largest purchaser of public employee health benefits in the state) brought together three large stakeholders—an insurer, a hospital organization, and a physician group—to integrate their systems and enhance their operations to create a more patient-centric model. The Blue Shield of California HMO, Catholic Healthcare West, and Hill Physicians Medical Group initiated a two-year pilot study in January 2010 that affected approximately 41,000 CalPERS members in Sacramento, Placer, and El Dorado counties. The two provider organizations and the insurer share a common cost goal and a global three-way budget. The payment mechanisms and contracts between them were not affected, which is to say that that hospital is still paid fee-for-service, and the physician group is still paid capitation.<sup>lxxxvii</sup>

In the first ten months, this effort led to a noticeable drop in hospital stays and readmissions.<sup>lxxxviii</sup> The average patient length of stay dropped by half a day. The total days patients spent in a facility dropped and patient readmissions dropped by 14% and 17%, respectively. The number of patients who stayed in a hospital for 20 days or more was cut in half. Estimated savings from these outcomes total \$15.5 million.

**Why It Worked:** Planning began in 2007, and agreements were signed eight months in advance of the January 1, 2010, start date, allowing adequate time for buy-in and trust to develop. This allowed Blue Shield, the insurer, to take the big step of sharing its pricing tool with providers. Also, the three stakeholders' IT systems didn't "talk" to each other at first, but they brought in IT assistance early on to improve data sharing. To encourage participation in the pilot program, CalPERS, the employer, played an active role and developed discounted premium incentives for employees and dependents.<sup>lxxxix</sup>

made. Part of this process involves **allowing adequate time** for relationships to develop and provider responsibilities to grow. As seen in the Florida Community-Based Care model, gradual change can have a powerful and pervasive effect on human service delivery, even in a very large and complicated market.

Across the board, the need for **clear communication** in all directions is paramount to the smooth operation of these coordinating entities, and that comes with an associated need for infrastructural investment on the part of states and providers. Standardized procedures, reliable points of contact, and up-to-date technology are all part and parcel of truly successful systems. Without a **strong administrative and governance structure** in place, it is difficult for states and coordinating bodies alike to keep tabs on and support the many providers in the increasingly decentralized world of human services. Closely associated with these administrative demands, coordinating bodies also often require new business processes and paths of payment,

especially in the cases of the Fiscal/Employer Agents and Accountable Care Organizations.

Finally, **quality control** is, as always in the human services field, paramount. With so many providers at the ground level, it is important to establish **clear, realistic, and trackable performance measures and reporting mechanisms**. This can be a delicate balancing act. Providers can have limited resources in terms of both staff time and money to devote to reporting, and they may also have limited technological capabilities. Despite these constraints, performance measurement is still crucial, and states and providers must work together to arrive at a workable solution. It should be noted that with regulatory controls in place, there will always be a floor for service quality, and the missions of the providers themselves often also support the healthy and respectful treatment of their clients. That said, as the numbers and networks of providers expand, it is increasingly important to monitor the quality and standardization of care delivered.

## Issue #3: Provider Payment Models

With state budgets tightly constrained, state agencies must look for ways to keep costs under control while still meeting the needs of constituents and honoring contracts. This pressure, along with the customer-centric developments in the field and an increasing emphasis on outcomes, has brought the question of how states will structure their payments to the fore.

Each of the main payment structures—Fee for Service (FFS), Capitation, Managed Care and Accountable Care Organizations, and Pay for Performance—has different implications for providers. As shown in Figure 7, all of these models present trade-offs to be made between payment risk, organizational flexibility, and overall affordability. Overall, assuming fairly set rates, FFS payments represent the least risk to providers because reimbursements are based upon the services billed; however these post-service payments leave providers little opportunity for investment or innovation. As seen in the health care sector, there are also limits to the affordability of this structure, and as such, it is likely that more cost-efficient alternatives to FFS will become more prevalent in human services. When faced with non-FFS payment models, it is important for providers to be aware of the associated risks and take steps to mitigate them in their contracts' terms.

This section outlines the distinguishing characteristics of the major payment models and highlights the benefits and drawbacks of each.

### ***Fee for Service Payments***

Fee-for-Service (FFS) payments have made their mark in the health services industry and are now widespread in the human services arena as well. The FFS delivery is a payment model where services are unbundled and paid for separately, thereby breaking down payments to compensate providers only for the services delivered. This is a payment model that runs counter to more traditional “lumped” grant funding for use across a given program and to capitated models, in which a provider is paid a designated amount per person to cover the costs of care.

While FFS may not be a national trend in all sectors of non-profit contracting, in human services there has been a clear perception of a shift away from bundled grant funding toward FFS.<sup>xc</sup> Recent data confirms this empirical observation; government agencies frequently employ more than one payment method for their human services contracts, but FFS structures, with unit costs either by time or individual/family cost units, have become a common form of payment. In 2010, 35% of agencies reported that they used time-unit-based costs of services, while 26% reported the use of individual/family-unit-based fees for service.<sup>xc<sup>i</sup></sup> The desire for increased accountability and the growing overall preference for the money to follow the client (generically speaking, not just with regard to the Money Follows the Person program described above) have promoted the growth of the FFS payment model in this field.

	Fee for Service	Capitation	Managed Care	ACO	Pay for Performance
<b>Payment method</b>	Payment tied to the delivery of a unit of service	Fixed payment per consumer	Payments divorced from volume, based on members	Payments attempt to balance FFS and shared savings incentive	Payment received upon meeting outcome
<b>Clients</b>	Eligible to receive services	Eligible to receive services	Enrolled with a specific insurance company	Assigned to ACO based on prior utilization patterns, open network	Eligible to receive services
<b>Care Coordination</b>	Generally provided by lead agency entity or state	Care coordination can be part of model to enhance services	Care coordination is a central component	Care coordination is central component	Depends on service
<b>Quality</b>	Links services to individual and their outcome	Quality-based incentives can vary	Reporting, quality-based incentives vary	Shared savings associated with meeting quality measures	Focuses on outcome rather than unit of service
<b>Provider Advantages</b>	Payment issued after service rendered	Prospective payment based on caseload or volume	Prospective payment based on caseload or volume	Prospective payment, with some FFS	Can create operational efficiencies, benefits successful providers
<b>Provider Risks</b>	Unstable revenue – depends on service provision	Must manage service volume and services to obtain profit	Volume and services must be carefully managed	Outcomes must be measured, movement to capitated model	Risk put on provider to obtain specific outcome, capacity issue to track outcomes
<b>Effect on Services</b>	Incentivizes units of service (low rates create negative incentive)	Providers forced to manage volume within controlled amount	Payment method may impact outcomes and quality	Outcome focus, change in provider landscape	Greater customer satisfaction, shorter service unit to manage risk
<b>Example</b>	Massachusetts Department of Youth Services Residential Services	Missouri Children's Division, Foster Care Case Management services	MassHealth	Vermont Health Care Reform Commission (HCRC)	Illinois Division of Rehabilitative Services, Job Placement

Figure 7: Payment Models Comparison

### FFS Considerations

There are advantages to the FFS model. It can be **attractive to providers**, especially multi-

faceted ones, because the **money follows the client**, and a natural preference for convenience suggests that clients are inclined to receive



multiple types of service through one provider when possible. This dynamic of provider attraction **depends largely on the rates set**, however; if they are set too low, FFS structures will not attract new providers, and quality of care can be affected. FFS also encourages new and existing providers to identify clients and to develop services that meet service demands.

An FFS payment structure also **promotes a system of care that meets client needs**. The service-by-service payments allow for patients who have complicated conditions to receive the care they need without hitting a preset per-person cost ceiling. The flexibility of the model is responsive to client needs; if one month assistance needs are higher and the next month lower, the payments made reflect that change in demand. With the payments tied to service delivered, the FFS structure also **discourages “cherry picking”** of low-needs clients.

For the payer, the FFS model also brings **enhanced transparency and traceability**. Rather than supplying an umbrella of funds that a provider can apply as needed within the overall contracted scope of services, payments administered are tied directly to claims of services delivered. This ties the direct service to the payment. If the proper data systems are in place, this would also allow for demographic and geographic trend analysis and forecasting.

There are also drawbacks to the FFS system. For one, it is **expensive**. The same structure that encourages care for the highest-need clients also **promotes the delivery of more and more expensive services** for all clients. In the health care industry, it has been noted that FFS may give an incentive for physicians to provide more aggressive treatments and more tests (including unnecessary ones) because payment is

dependent on the quantity of care, rather than quality. Without any cap for the client to consider and with most or all services reimbursed fully, the client and the provider have **little incentive to use preventative strategies**. At minimum, it is fair to say that when costs and rates diverge, it can distort the mix of services offered and delivered. This is as true in human services as in health.

One of the biggest challenges that FFS present to human services providers and the populations they serve is the relatively unstable nature of the revenue.<sup>xcii</sup> Costs per payment may be determined prospectively, but **funds are often paid as reimbursements to claims after the fact**. The unpredictable nature of this income structure can make it difficult for organizations to plan for the future and, especially in the case of smaller entities, to keep up with administrative costs. It also limits innovation, for although providers may want to respond to the needs they see unfolding in their client populations, the payments they receive are set to cover the costs of the services just provided, not the ones needed in the future.

It is also important to note that although the FFS model ties payment to service, it is not immune to improper payments. The federal Government Accountability Office (GAO) reported in July 2011 that the federal government spent nearly \$48 billion on improper Medicare Part A and Part B FFS programs in 2010. The 10.5% error rate was lower than the 12.9% from 2009, but the sheer size of the Medicare program makes it difficult to eliminate erroneous payments completely.<sup>xciii</sup> In order to mitigate such risks, the GAO for CMS has setup the principles below, which could also be easily applied to human services:<sup>xciv</sup>

- 1) Strengthen provider enrollment standards and procedures to reduce the risk of enrolling providers intent on defrauding the program.
- 2) Improve post-payment reviews to help ensure that payments are made correctly the first time.
- 3) Focus post-payment reviews on vulnerable areas.

Some state agencies have attempted to limit the downside of FFS payments through service referral authorization. In that case, a state or separate case management entity identifies the required service and creates a service referral, which prompts service delivery. The state or managing entity can then restrict the number or cost of services through referrals.

As allowable expenses change and additional populations become eligible, efforts are being made to access Medicaid, Medicare, and commercial insurance payments for services not traditionally associated with these sources. These sources all pay on an FFS basis, and state agencies have restructured provider payments to better map to new payers. Along with this payment opportunity, there is some concern at the state level that services may be “driven by the funding” rather than allow finance systems to support high-quality service delivery systems of greatest need. Still, overall, the focus on meeting the needs of individuals in the provision of service is mirrored by issuing payment based on an individual unit of service.

*Illinois adopted a proscriptive FFS payment model for its non-residential Developmental Disability and Mental Health Services in 2004.<sup>xcv</sup> Just two years after implementation, Illinois identified a noticeable effect from the FFS system. According to a state report, the FFS reimbursement system had a “huge” impact on the share of financial risk assumed by providers and the state.<sup>x cvi</sup> Supernormal costs, which would otherwise be absorbed by providers through expanded operations in a capitated or more bundled model, were shared by the state, which does not have the providers’ flexibility to alter its pool of clients or avoid high-risk clients. It should also be noted that the FFS system did not help Illinois to weather the most recent recession; in 2009 the state had trouble making payments, which caused providers to take out lines of credit, pay interest, lay off staff, and close offices.<sup>x cvii</sup>*

*What Went Wrong: Capped proscriptive payments translated into limited services and consumer choice, as well as cost-minimization amongst providers, which to a degree negatively affected quality of care.*

### **Capitated Rates**

Under a capitation payment model providers receive a fixed fee for each member in receipt of services or enrolled in a specific program, regardless of the intensity of services provided. Vocational rehabilitation services such as job placement have used this model, and most recently child welfare agencies have been piloting the model for residential services and after-care. The payment is generally based on a per person cost for a period of time (day, week, month). Capitated rates are found in health care, elder services such as nursing homes or

long-term care, some community-based models, early intervention and in child welfare.

Within the capitated model, there are different fee structures:

- *Charge-based fees* are structured high enough to cover variable costs. These minimize risk to the provider that the client volume will be too low to cover the fixed costs. Providers have the ability to either negotiate rates with subcontractors or to assist in managing the rate.
- *Prospective payments* are fixed payments set in advance, regardless of the individual.
- *Per diems* are typically used in hospitals and long-term care facilities. Providers are paid a set rate per consumer day. In the recent Texas DFPS lead agency procurement, contractors will be paid based on the same per diem rate per consumer. The responsibility lies within the vendor to manage services and their own risk.
- *Global rates* are similar to prospective payments, issued in advance to cover all services for a given condition regardless of how or what services are delivered.<sup>xcviii</sup>

#### *Capitation Considerations*

Capitation, similar to MCO and ACOs, requires provider agencies to make fiscal management decisions that differ from regular FFS. There is a **risk and return** in the model as **providers bear the risk that the cost of providing the services might exceed the actual capitation payment.**<sup>xcix</sup>

In order for providers to make a profit, the volume of services must be decreased to increase profits. From a state perspective this drives outcomes and quality services due to the

financial risk on providers. It is also a preferred model in that it **controls costs**. Providers face challenges in managing services required for consumers against the capitated amount. This can result in a shorter unit of service or less units to drive down costs.

The capitation rate, similar to the MCO model, **encourages low-cost service utilization** rather than the highest cost service often seen in FFS. That being said, there are some **benefits to the model for providers:**

- Providers **receive a payment regardless of what services are rendered.**
- Revenue is **predictable and timely**. It is not tied to FFS – providers get paid regardless.
- **Payments are received prior to services being delivered** and in a sense extend a credit to providers, minimizing cash flow risk. Services must be documented, however.
- The documentation required for a capitated rate is often less than with other payment models. This translates to **reduced administrative burden and expenditures.**<sup>c</sup>

*MassHealth is exploring the possibility of returning the Senior Care Options program to a capitated three-way contract.*

In July 2011, CMS announced that it is offering opportunities to align financing between Medicare and Medicaid to support improvements in care for dual eligible individuals. Both FFS and capitated payments were named as financing options for this alignment effort.

MassHealth has declared its intent to pursue a capitated, three-way contract model for dual eligibles ages 21 to 64. Enrollees may be HCBS waiver enrollees.

The three-way model allows the state to blend rates to achieve savings. This will be a state-wide demonstration, with solicitations for bidders expected in early 2012 via a joint procurement from Medicare and MassHealth (pending federal approval of the Massachusetts proposal). Provider networks will not be limited; single-use agreements will be available for members utilizing providers that are not within the network.

### ***Managed Care and ACOs***

Managed care can mean many things. For the purposes of this report, a **Managed Care Organization (MCO)** is an organization that manages a network of providers to deliver coordinated care to its enrolled members. As described earlier in this report, an **Accountable Care Organization (ACO)** is a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population.<sup>ci</sup> From the state perspective, MCOs provide similar reimbursement models to ACOs and are useful as a point of reference.

A state agency contracts with MCO programs to manage the care of enrollees. Based on the

level of need, the state and the MCO arrive at a capitated rate (see section above) for each individual enrolled in the plan. In return, the MCO contracts with a network of providers to deliver health care services to all of those enrollees. The state monitors the MCO to ensure that access to services and quality of care is provided.

### ***Managed Care considerations***

For providers, MCOs are a payer, and each one requires a separate credentialing process, a separate set of allowable services and prior authorizations, and different billing procedures. In short, each payer adds an **administrative layer** to each provider's delivery of service. If the administrative strain becomes too great, services may be limited, or providers may request permission from the MCO to provide certain more manageable levels of care for certain services.

As with insurance payers, **providers are often reimbursed on an FFS basis by MCOs** and may be enlisted to participate in care management programs or pilots that the MCO runs. As the health care industry moves toward linking payments with outcomes and performance, providers may see MCOs introducing this element to providers as well. This means that **going forward, MCOs may ask providers to accept a capitated payment rather than a traditional FFS payment, thereby shifting risk onto providers.**

There is a significant administrative benefit to a managed care model. MCOs bring a **high level of care management expertise and experience** to enrollees. Because MCOs

are not state agencies, they have more flexibility in contracting with providers and testing new techniques, all without adding to state staff rolls or incurring the huge operational expenses required to run a full managed care program.

Regarding reimbursement, MCOs provide some **predictability regarding expenditures and payments** in a given year. Of the three main cost drivers for Medicaid managers—enrollment, rates, and utilization—only enrollment needs to be predicted under an MCO. The MCOs set their own rates and are tasked with managing their own utilization. Once a state contracts with an MCO and projects estimated enrollment, the state can reasonably budget for those expenses and focus on other program components.

**Vigilant oversight** of MCOs is imperative. While MCOs are unlikely to deny care specifically for profit, the incentives involved are structured so as to minimize care. This is because if an MCO spends less than the revenue it brings in from its capitated payments from the state, it keeps that revenue. Rates are set with the aim of providing the MCO with enough funding to pay for services and to administer the programs, but fewer MCO expenditures translate into higher profit margins.

#### *ACO Considerations*

Turning to ACOs, with so few in practice, there are still a lot of unknowns for providers and state agencies alike. With ACO reimbursements, **payments may include more capitation and will likely involve outcomes measures and performance criteria**. As with MCOs, this

shift towards capitation means that provider agencies would receive a flat monthly fee to provide all necessary services, either to an individual or for a given diagnosis. This changes the considerations for providers when negotiating their rates under this model.

#### ***Pay for Performance Contracts***

With greater focus on the individual in terms of provision and purchase of service and the customer-centric model, there is a national trend of tying payment to outcomes of the individuals served. Economic constraints have focused on doing more with less and with limited funds states want to prioritize where to invest resources and maximize consumer outcomes. In a 2010 Urban Institute study, approximately 17% of human service providers were found to have a performance-based contract.<sup>cii</sup> These statistics differ across subsections of human service providers. For example, 50% of state child welfare agencies have performance-based contracting.<sup>ciii</sup>

The growth of performance-based contracting can be seen in a variety of forms across health and human services. Performance-based contracts have moved beyond just performance reporting; step-up/step-down, share-in-savings, hold-back, and milestone approaches have all been implemented and directly tied payment to performance.<sup>civ</sup>

In 2010, Wisconsin took a big step towards performance-based contracting when Governor Jim Doyle signed legislation that will establish incentive contracting for residential child care centers for children and youth. Illinois and

Indiana have made similar steps for child welfare contracting. Alaska's Temporary Assistance Program offers a benchmarking bonus that allows contractors to earn additional compensation for exceeding contract performance standards. Performance-based contracts have become the norm in major markets like New York City, where payments for major programs like Back to Work are issued in step with the achievement of individual and aggregate milestones.

Such changes have not gone unnoticed or unopposed. In November 2010, Governor Christine Gregoire of Washington State called for all new agency contracts to incorporate performance contracting standards. In response to a subsequently issued RFP for performance-based contracting for the state's Children's Administration, Washington's Federation of State Employees filed a lawsuit asking the court to stop the state from moving forward with its procurement. The injunction was granted on May 13, 2011,<sup>cv</sup> and the associated procurement project was withdrawn less than two weeks thereafter.<sup>cvi</sup>

#### *Pay for Performance Considerations*

While performance-based contracting is not a new concept, the wave from the early 2000s had a relatively minimal impact due to limited systematic collection of data and outcomes measurement. As data collection methodologies improve and provider organizations are contractually required to collect such data, it is easier for state agencies to track payment to outcomes. The **requirement to track data and outcomes is a capacity issue** for many providers, especially non-profits, as their service delivery and

purchase of service moves towards quantifiable results.<sup>cvi</sup>

*A Social Impact Bond is a contract with the public sector in which a government agency commits to pay private investors a return on services they fund if (and only if) social outcomes improve at an agreed-upon rate*

**Social Impact Bonds (SIBs)** are a nascent funding mechanism that links performance-based pay with service delivery. An SIB is a contract with the public sector in which a government agency commits to pay private investors a return on services funded if (and only if) social outcomes improve at an agreed-upon rate. These bonds introduce a new administrative layer, known as an intermediary, and a new funding source: private investors seeking return on their investment. The intermediaries work with government agencies and private investors to establish mutually agreeable terms, including performance standards and rate of return on investment. The investors put up the money, solicited and held by the intermediary, who is also responsible for procuring and paying for the services to be delivered.

**Providers submit proposals stipulating to meet the performance demands of the investment and are expected to meet those demands.** If, at the end of the agreed-upon term of service, the providers have achieved the desired social outcome, the government will reimburse the investors their original investment, plus a profit. SIBs are also a potential new market payer.

To date there is only one SIB that has actually been implemented—a project through the U.K. Ministry of Justice for the Peterborough Prison launched in September 2010. Though largely

untested, the Obama administration has allocated \$100 million for “pay for success” initiatives in seven pilot areas, including job training, education, juvenile justice, and care of children’s disabilities.

States have taken notice and are beginning to explore the idea as well. Massachusetts issued the first related RFI earlier this year and received responses from many interested parties. Minnesota has already approved a pay-for-performance pilot program in this year’s budget. The Minnesota legislation, known as the Human Capital Performance Bond, requires the implementation of an appointed oversight committee, to be comprised of representatives from the state Departments of Human Services, Employment and Economic Development, and Administration, as well as a representative from a non-profit with pay-for-performance experience. There is no third-party intermediary in this system, rather a new layer of state administration. The Minnesota model is based upon Twin Cities Rise!, a successful pay-for-performance contracting program with a 13-year history in the state.<sup>cviii</sup>

Contracts executed under this program will specify the service to be provided, its timeframe, and the outcome required for payment. Payment for services will depend on the state’s determination that the state’s return on investment is positive, a finding that will be calculated based on the amount of income taxes and other revenues generated that would not have been collected without the service and the costs avoided by the state through the provision of service.<sup>cix</sup>

With SIBs in the U.S. just taking shape, it is difficult to know exactly how the rise of this nascent performance-based model will impact

providers. The **impact will depend upon who winds up bearing the risk** in this new structure. In the Peterborough model, risk is not borne by the providers; they are paid by the SIB intermediary regardless. There, it is the private-sector investors who bear the risk of not recouping their principal if the providers do not produce their promised results. In the U.S., with no precedent and an early recommendation for performance incentives for providers at a recent presentation by Social Finance, U.S., it may be that providers may yet bear some of the risk in an American SIB model.

### ***Keys to Success and Related Challenges***

There is no one payment model that is inherently more successful than the others, but that does not mean they are all equally beneficial to the state and its providers. With the high costs and hyper-service incentives of FFS reimbursements by now familiar, it is worthwhile to consider the challenges ahead as states explore versions of capitated, person-centric, and performance-based payments.

The move to issue payment based on the number of people expected to be served increases the risk incurred by the provider because funds are received after service delivery rather than before. Such a system requires an adequate, stable funding base to manage cash flow and ensure responsive services and supports.

Likewise, while performance-based contracting mitigates risk for the state agency as payment is not due if the services are not provided according to pre-set measures, it increases risk for providers.<sup>cx</sup> Agency expenditures and cash flow must be managed even more closely on the provider end as well. Still, the state

### Provider Scorecards

*Provider scorecards allow agencies to effectively rank the efficiency and effectiveness of their providers and can be used as a basis for selective contracting and the development of selective provider networks. By bringing together the various datasets collected such as utilization data, provider cost data, client case information, and other metrics depending on the specific provider type (i.e., residential settings, employment services, juvenile detention centers, etc.) agencies are exploring avenues to scorecard measures for:*

- *Administrative efficiency*
- *Outcomes*
- *Utilization*
- *Community linkages*
- *Client satisfaction*
- *Cost per client*

*Using this information, state agencies would be able to develop procurement policies that reward providers with efficient and effective systems and programs. Scorecards offer a standardized process by which to compare options and are most useful as a method of comparison across similar services.*

*Scorecards can also be helpful for providers because they provide focus and clarity around the purchaser's priorities. When managers understand how they will be measured they can provide clear guidance and feedback to their employees, providing focus and energy toward a shared set of desired outcomes. Underperforming providers should be provided with assistance to improve their scores.*

maintains a vested interest in the providers' success because it correlates with the provision of needed human services. Because the vendor and state have a shared interest in the results, both parties are aligned to work together to understand the business needs and organizational processes.<sup>cxii</sup>

To further mitigate their exposure, human service agencies are pursuing alternative funding sources and are bringing new payers to the market such as:

- **Medicaid:** Human service agencies are finding ways to structure services and amend the Medicaid State Plan so that the services are covered under Medicaid. New York State is accessing Medicaid funds for foster care services under the Home and Community-Based waiver, a first for child welfare agencies. For Long Term Services and Supports (LTSS) programs, Medicaid is the major funding source at 77%. States have reconfigured the Home and Community-Based Waiver to include LTSS services.
- **Private Insurance:** With specialized populations such as Autism Spectrum Disorder (ASD) putting stressors on the system, state agencies are working to incorporate ASD into insurance requirements. In the case of ASD, a total of 33 states and the District of Columbia have laws related to autism and insurance coverage. At least 26 states—Arizona, Arkansas, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Pennsylvania, South Carolina, Texas,



Vermont, Virginia, West Virginia and Wisconsin—specifically require insurers to provide coverage for the treatment of autism.<sup>cxii</sup>

- **Mental Health Parity:** Enacted in 2008 and effective beginning in 2010, the Mental Health Parity and Addiction Equity Act requires that aggregate and annual dollar limits for benefits related to mental health or substance abuse disorder and be no lower than medical or surgical benefits under a group health plan. The inclusion of substance abuse disorder amended the original Mental Health Parity Act of 1996, which did not include substance abuse services.
- **Health Care Reform:** Health care reform will have numerous impacts to the health and human services systems. The drive to require insurance coverage for all citizens will bring additional private and subsidized payers to the table for health and human services. The impact here in Massachusetts will not be as significant as most other states as its own version of health care reform has been in effect since 2006.

As states work towards payment structures and risk mitigation strategies that suit their needs, there are a few key high-level issues to take into consideration.

For one, there is the issue of **when payments are delivered**. FFS payments are typically made as reimbursement, meaning after services have been provided. This structure does promote the payment of services as delivered and received, but it also puts providers in a difficult position. Post-service payments can negatively affect a

service provider's ability to secure financing, enhance its offerings, and survive transitions. Prospective payments, though more dependent on projections, afford providers some flexibility, which in turn enables them to meet state and client needs.

As states consider significant changes to their payment structures, it is also important to remember that any substantial changes to the flow of funds or the associated reporting requirements necessitates a **graduated adjustment** period to allow for kinks in the system to be ironed out. Many providers have limited staff and technological resources, and it is therefore critical to their survival that expectations and paths to compliance be laid out clearly and reachable.

Lastly, states must find a way to strike the right **balance of incentives**. In the health care industry, the incentive to over-serve in a pure FFS model has become evident, but that doesn't mean a swing back to capitation will solve all problems. Regulations, quality control, and monitoring remain essential components of high-quality human service delivery, especially as the field decentralizes more and more. Finding revealing yet non-obtrusive ways to track performance will help states to determine if clients are feeling any negative impacts under revamped payment structures.

## Conclusion: Developments in Massachusetts

### **Growth Populations in Massachusetts**

Early intervention statistics indicate that **Autism Spectrum Disorder** diagnoses are on the rise in Massachusetts. In a 2011 study, one in 129 children in Massachusetts born between 2001 and 2005 were found to have enrolled in early intervention programs for an autism spectrum disorder by their third birthday. Over the five-year period, the proportion of children aged 3 and younger getting treatment rose from one in 178 among children born in 2001 to one in 108 for those born in 2005 -- a 66% increase.<sup>cxiii</sup>

Massachusetts belongs to the state majority that requires insurers to provide coverage for the treatment of autism. However, in early September 2011, California health insurance companies made an argument that local taxpayers should pay for services for children. The argument has reached federal levels where the Department of Health and Human Services will be defining what an essential benefit package is at the end of this year. The exclusion of autism services could have enormous impacts.<sup>cxiv</sup>

Massachusetts children with ASD and their families served under Part C may receive intensive behavioral interventions, a set of specialized services provided in addition to those regularly delivered through the early intervention program. The Massachusetts Department of Public Health currently contracts with 10 private providers who provide intensive behavioral interventions to eligible toddlers and their families. On average, toddlers are 25 months of age at entry to these services,

though many receive other standard early intervention services earlier. Growth in enrollment for the intensive services has been phenomenal and has resulted in a re-examination and enforcement of more stringent eligibility criteria.

Potential for Provider Participation: Autism Spectrum Disorder	
<b>Provider Opportunity:</b>	<ul style="list-style-type: none"><li>• With a growth in enrollment for intensive services, DPH could release additional funds for services requiring additional providers.</li><li>• Insurance companies in Massachusetts are required to cover autism services.</li><li>• The adult autistic population is not being discussed at the same level as children. As the youth population ages, services for those 18 and plus will be in need.</li></ul>
<b>Provider Challenge:</b>	<ul style="list-style-type: none"><li>• Entry into an already established provider pool can be difficult.</li><li>• Changes to benefits covered under Health Care Reform.</li></ul>

**Traumatic Brain Injury (TBI)** also represents significant a significant growth population in Massachusetts, and their needs are great. According to the Massachusetts Statewide Head Injury Program, there are 4,000 eligible individuals in the state, and only approximately 1,000 of these people are covered for these services.<sup>cxv</sup> Seventy individuals with TBI receive state-supported residential services costing \$8.7 million per year. Other individuals receive a broad range of services including day programming, respite care, assistive technologies, and community supports which cost an additional \$4.7 million per year. There are also residents with TBI who do not meet the eligibility requirements yet have a need for services.

Massachusetts currently has two home and community-based services waivers to serve Medicaid-eligible people with Acquired Brain Injury (ABI) move into community settings. Waiver applications are being accepted for individuals who are currently in nursing homes or rehabilitation hospitals.

Potential for Provider Participation: Traumatic Brain Injury	
<b>Provider Opportunity:</b>	<ul style="list-style-type: none"> <li>Multiple service contracts have been released by the State to serve the TBI population including community services, clinical services, residential, transportation and recreation.</li> <li>TBI has been linked to increasing the risk of long-term neurodegenerative diseases, especially for veterans. The mental health services for TBI and veterans will increase during the next decade.<sup>cxvi</sup></li> <li>Community-based services for ABI waiver candidates.</li> </ul>
<b>Provider Challenge:</b>	<ul style="list-style-type: none"> <li>There is a national struggle to serve the TBI population, specifically veterans, in terms of meeting their service needs and successful strategies.</li> </ul>

According to the National Center for Veterans Analysis and Statistics Veterans Population Model,<sup>cxvii</sup> Massachusetts had a total **veteran population** of about 393,700 in 2010, age breakdown shown in Figure 8, with the greatest concentration in Middlesex and Worcester Counties. Of these, 75,413 received treatment

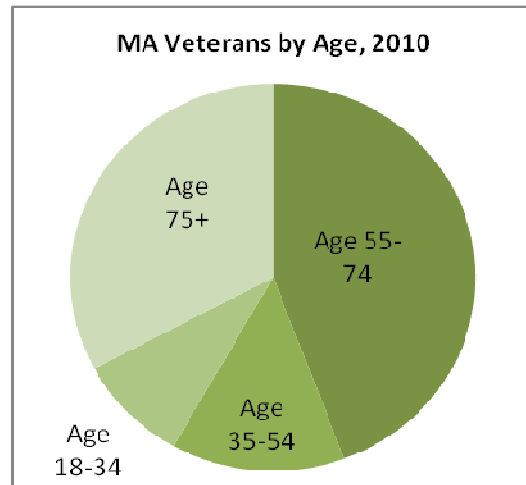


Figure 8

at a VA health facility. The vast majority of Massachusetts veterans are male (93.3%), but the percentage of female veterans noticeably larger amongst younger veterans; of veterans ages 18 to 34, approximately 17% are female. In 2010, Massachusetts spent nearly \$775.8 million in compensation and pensions, \$115.1 million in education and vocational rehabilitative services, and \$848.5 million in medical care.

Potential for Provider Participation: Veterans	
<b>Provider Opportunity:</b>	<ul style="list-style-type: none"> <li>As soldiers return home over the next year from engagements in Iraq and Afghanistan, the needs for mental, medical and behavioral health services will rise.</li> <li>TBI for veterans is a growing concern for the Massachusetts Rehabilitation Commission and they seek to improve systems of care to serve veterans.</li> </ul>
<b>Provider Challenge:</b>	<ul style="list-style-type: none"> <li>A support network for female veterans in Massachusetts has taken on extra significance as the population grows and their needs are unique to their counterparts.<sup>cxviii</sup></li> <li>Growth in aging veterans brings on strain in services and growth in costs.</li> </ul>

From 2000 to 2010, the **elderly population** of Massachusetts (age 60 and older) grew by 16%, compared to a 1.5% rate of growth in the same age bracket for the previous ten-year period. In the next ten years, the Executive Office of Elder Affairs projects another 28% increase to reach an elderly population of over 1.6 million. The towns with the highest growth in this population were all very small; the 60 towns with the highest growth rates from 2000 to 2010 were all under 10,000 people. Areas with counter-trending decreases amongst the 60+ age group included Adams, Somerville, New Bedford, Medford, Arlington, and Dedham.

Potential for Provider Participation: Elderly Population	
<b>Provider Opportunity:</b>	<ul style="list-style-type: none"> <li>• Waiver programming in Massachusetts to serve individuals in their community</li> <li>• Growing untapped service need of 28%</li> </ul>
<b>Provider Challenge:</b>	<ul style="list-style-type: none"> <li>• Meeting service demand given changing needs of Boom generation</li> </ul>

As noted in the introduction, the 7.4% **unemployment** rate in Massachusetts is lower than the national average. Still, even with this relatively lower rate, Massachusetts faces a population of about 260,000 unemployed in need of work supports and other services. The most positive growth rates have come in the Professional/Business, Leisure/Hospitality, Construction, and Other Services sectors.<sup>CXIX</sup>

Demand for basic human services overall has been climbing. In Massachusetts, the number of people collecting SNAP benefits increased to nearly 750,000 in 2010, up from 456,192 in 2007. The average monthly caseload of total TANF recipients for 2010 was 97,472, up 3% from 2009 and up 7% from the year before that. The long-term unemployment picture in Massachusetts is similar to the national picture;

40.3% of the unemployed have been jobless for 27 weeks or longer.<sup>CXX</sup>

Potential for Provider Participation: Unemployed	
<b>Provider Opportunity:</b>	<ul style="list-style-type: none"> <li>• The long terms unemployed have unmet employment service needs.</li> <li>• Specific populations such as refugees and immigrants now require specialized assistance.</li> </ul>
<b>Provider Challenge:</b>	<ul style="list-style-type: none"> <li>• Employment service needs are higher in specific communities such as Fall River, New Bedford, and Lawrence.<sup>CXXI</sup></li> <li>• Underemployment affects approximately 200,000 individuals and rising. Service needs for the underemployed differ and are often harder to address.<sup>CXXII</sup></li> </ul>

### Youth Violence Community Grants

In early October 2011, Governor Patrick released \$9.7 million in funding to 11 municipalities in Massachusetts with high levels of youth-related homicides, assaults and serious injuries. The funding is a result of the Safe and Successful Youth Initiative, which seeks to address the growing youth violence issue. The funding is appropriated to the local community which should result in a need for providers to deliver the youth services. An additional \$262,000 was appropriated for trauma response training and to hire a program manager to oversee the program. Opportunities for providers include:

- Trauma response training
- Youth violence and youth development programs
- Community-engagement
- Violence prevention
- Identification of victims or perpetrators of shooting or stabbing violence
- Trauma counseling
- Employment and education services

Providers will need to work directly with municipalities with grant awards:<sup>cxxiii</sup>

Boston	\$2,264,000
Brockton	\$442,557
Chelsea	\$900,000
Fall River	\$807,832
Holyoke	\$441,400
Lawrence	\$800,000
Lowell	\$900,000
Lynn	\$788,832
New Bedford	\$882,923
Springfield	\$800,000
Worcester	\$710,065

value. While this is not an exhaustive list and other opportunities may exist, it does provide a summary of the scope and breadth of services for these growth populations. The summary also confirms that the State is paying attention to these key populations.

Figure 9: State Contracts and Opportunities for Growth Populations

residents who qualify for nursing facility or other institutional care but want to live at home. This program helps frail elders, people with intellectual disabilities, young children with an ASD diagnosis, and adults with traumatic brain injuries.

Since 2010, the waivers associated with **participant-directed (PD) care** in Massachusetts have been the **Adult Residential Waiver, the Adult Supports Waiver, and the Community**

**Living Waiver.**<sup>cxxiv</sup> The Adult Residential Waiver is for individuals who need a residential placement with around-the-clock supervision and staffing due to significant behavioral, medical, and/or physical support needs. The Adult Supports Waiver serves individuals who can live in their own home or apartment or family home. The Community Living Waiver is for individuals who can live with their family, their own home, or the home of someone else and do not need continuous supervision. All three of these include the option of self-direction, but as of now only a small fraction of the 12,000 consumers eligible under the adult waivers are currently self-directing.<sup>cxxv</sup> Key populations that do not have access to this service model are persons with behavior or mental illness and those with HIV/AIDS. Please see Appendix I for a state-by-state breakdown of PD services.

In addition, there is also an Autism Waiver, known as **the Autism Renewal Waiver**, and under this program participants are required to self-direct (via their parents).<sup>cxxvi</sup> At any one time the Autism Renewal Waiver serves up to 130 children, birth through age 8, and unlike its predecessor, it reserves capacity (10 slots) for children who are age 3 and transitioning out of an Early Intervention Program. This waiver allows children to receive expanded habilitation and education services for a total of three years. This service consists of one-to-one interventions carried out in the child's home and community. At the conclusion of the three years of intensive in-home services, a child may access ongoing supplemental services such as community integration activities and respite until his or her ninth birthday.

Massachusetts also has a **Personal Care Attendant program** for persons with long-term disabilities through MassHealth, which serves approximately 20,000 eligible consumers.<sup>cxxvii</sup> Participants are responsible for the finding, hiring, training, and firing (if needed) of their own PCA. Through Rewarding Work Resources, Inc., a non-profit organization, MassHealth maintains a PCA Directory, which allows users to search for PCAs based on location, language, experience, and other factors.<sup>cxxviii</sup>

*Two of the primary challenges in the PD market are delivering education to and providing support for consumers.* It can be difficult for consumers to understand the benefits that PD programs would afford them through enhanced control over their own care, and outreach on this front has been variable. PD services through the three adult waivers are complex, and efforts to provide consistent education on the options available are being made; however the complexity of the program has proven to be a significant challenge.

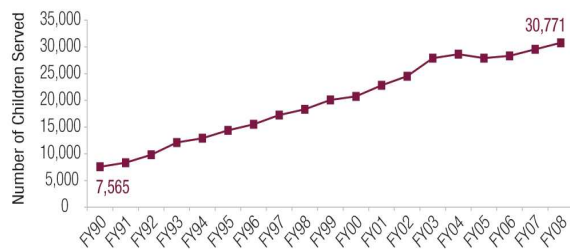
Potential for Provider Participation: Community-Based and Participant-Directed Services	
<b>Provider Opportunity:</b>	<ul style="list-style-type: none"> <li>• Range in Home and Community Based and other waivers allows greater innovation for service delivery for contracted providers.</li> <li>• Need for locally based providers as services move into the community.</li> </ul>
<b>Provider Challenge:</b>	<ul style="list-style-type: none"> <li>• Delivering education and providing support for consumers in the program.</li> </ul>

### ***Coordinating Bodies***

The Massachusetts **Department of Children and Families** (DCF) has had a **lead agency** model since 2006. The original Massachusetts RFP for lead agencies emphasized the creation of a community-focused, integrated service model that was accountable to both families and

communities. Lead agencies here are responsible for managing a strong area-based system to improve and expand the services that can be delivered locally to families and reduce the use of long-term residential placement by supporting at-risk children with their families at home when possible.<sup>cxix</sup> Lead agency funding has decreased sharply since inception due to budget cuts restricting the role of current contractors.

Figure 10: MA Early Intervention Recipients



Source: MDPH Early Intervention Program.

As shown in Figure 10, the number of children who receive **early intervention services** through the Massachusetts Department of Public Health continues to grow. To coordinate efforts for this population at the state level is the **Massachusetts Interagency Coordinating Council (MICC)**, which assists and advises the Department of Public Health in this field. The MICC is comprised of parents, professionals, and providers, including representatives from the Departments of Early Education and Care, Elementary and Secondary Education, and Developmental Services. The Massachusetts model is relatively centralized; unlike other states, where there may be a county- or even sub-county-based system of local councils, in Massachusetts the network of programs with overlapping boundaries operate under contract with the state. The programs' boundaries

overlap, and families can choose their program that best suits their needs.<sup>cxix</sup>

### Teen Parenting Lead Agencies

In March 2011, Governor Patrick released \$3 million in grants for local teen parenting programs. The funds were awarded to community-based agencies who will serve as lead agencies. These agencies will partner with local organizations, schools and education programs to provide services to pregnant and parenting teens. Services to be contracted will include assistance to complete high school education, help infants and toddlers obtain positive social and developmental outcomes and engage in positive family planning in the future. While the contracts for the lead agency entities have been awarded, this is an alternative use of the coordinating body discussed throughout the report. The model provides an opportunity for local partners to contract with the lead entity and provide services.<sup>cxix</sup> There is a call for innovative approaches to the following service areas:

- High School General Education Degree (GED) programs
- Early childhood and education programming geared at parenting trends
- Family planning

For its **fiscal management of participant-directed services** under the Adult Residential, Adult Supports, Community Living, and Autism Renewal Waivers, Massachusetts contracts with a single Financial Management Services provider, which helps to streamline operations and administration across the waiver programs. For the Personal Care Attendant program through MassHealth, there are three fiscal



intermediary vendors.<sup>CXXXII</sup> PCA workers are represented by the SEIU health care workers union.<sup>CXXXIII</sup>

**Managed care** in Massachusetts takes a few different forms under state Medicaid waiver programs. The two largest managed care programs in MassHealth are the **Managed Care Organization (MCO) program** and the **Primary Care Clinician (PCC) Plan program**. MCOs are organizations that look and act like traditional insurance companies – they contract with a network of providers to deliver care. MassHealth contracts with MCO programs to manage the care of enrollees, who receive a designated “rating category” based on the severity of their condition(s). For each rating category, the state and the MCO arrive at a capitated rate for each individual enrolled in the plan, and the MCOs contract with a network of providers. The PCC Plan consists of physicians, independent nurse practitioners, community health centers, acute outpatient hospitals, hospital licensed health centers, and group practice organizations tasked with coordinating care for a nominal fee per enrollee. **ACOs are beginning to appear** in Massachusetts and have strong support at the state level, especially regarding the potential cost savings of preventative and coordinated care.<sup>CXXXIV</sup>

The Children’s Behavioral Health Initiative (CBHI) is also establishing coordinating agencies for children and families in receipt of services. The CBHI seeks to place family and children at the center of the service delivery system and builds an integrated system of care and services around them. This program focuses on the consumer’s needs and satisfaction. Services required include primary care providers are required to conduct a standardized behavioral

health screening, child visits, and provides enhanced home and community-based behavioral health services.

The CBHI resulted in the creation of Community Service Agency (CSA) entities that provide the service referral, enrollment, and discharge services.<sup>CXXXV</sup> CSA serves as the coordinating entity for the individuals served. “A Community Service Agency (CSA) is a community-based organization whose function is to facilitate access to, and ensure coordination of, care for youth with serious emotional disturbance (SED) who require, or are already utilizing, multiple services or who require or are already involved with multiple child-serving systems (e.g., child welfare, special education, juvenile justice, mental health) and their families”.<sup>CXXXVI</sup> There are 32 CSAs across the state, 29 of which overlap with DCF service areas. Vendors have already been contracted to provide this role.

Potential for Provider Participation: Coordinating Bodies	
<b>Provider Opportunity:</b>	<ul style="list-style-type: none"> <li>• Become an authorized provider for CBHI services. Service opportunities include: Therapeutic Mentoring (TM), In-Home Behavioral Services, Family Support &amp; Training (FS&amp;T), and In-Home Therapy (IHT).</li> <li>• Work with your local Teen Parenting Lead Agencies, the Financial Management Services provider, the CSA or other coordinating bodies to obtain service referrals.</li> </ul>
<b>Provider Challenge:</b>	<ul style="list-style-type: none"> <li>• DCF lead agencies have consistently faced budget cuts. This is a challenge for the contracted provider and any service providers as less funding exists for services.</li> <li>• Consumers more empowered to choose how and what services they desire. Coordinating bodies must manage demand for services with limited budget.</li> </ul>

## **Payment Structures**

As noted above, Massachusetts was one of 13 awardees in the last round of **Money Follows the Person (MFP) grant funding**. Over the next five years, Massachusetts will receive \$110 million in federal funds as part of this program, which supports seniors and individuals with disabilities so that they may live in their own homes or in community settings. This funding will support the transition of more than 2,200 Medicaid-eligible individuals from institutional settings into community-based care. As part of this effort the state will make a robust effort to identify eligible participants, counsel individuals about community living options, and provide transition and long-term support services.<sup>cxxxvii</sup>

Plans for the MFP program<sup>cxxxviii</sup> state that enhancements to transition services will include competitive procurements with independent living, behavioral health, and disability contractors. Anticipated procurements include regional transition coordinators, case management, and direct service providers. Case managers will be mobilized to provide educational materials and information about recognizing and reporting abuse, neglect, and exploitation. Recognizing the importance of the housing piece, an MFP Housing Action Plan has been sketched out. That plan will build on existing Department of Housing and Community Development and local housing authority collaborations.

The Kaiser Family Foundation provides a service-by-service breakdown of benefit **fee-for-service reimbursement** methodologies by state. According to the most recent data available (2008), in Massachusetts, institutional and hospice care are both reimbursed prospectively per diem, but home health

services, personal care services, occupational therapy, physical therapy, and services for speech, hearing, and language disorders are all FFS.<sup>cxxxix</sup> Unlike some other states,<sup>cxl</sup> Massachusetts does not reimburse fractions of service fees for any of these categories.

Because the transition to unbundled payments made such an impact on the health care industry, it is instructive to look at developments there to inform unbundled payment plans in the human services sector. In 2008, **Massachusetts convened a Special Commission on the Health Care Payment System** to “investigate reforming and restructuring the system to provide incentives for efficient and effective patient-centered care and to reduce variation in the quality and cost of care.”<sup>cxli</sup> The Commission noted that the FFS payment system rewards volume rather than outcomes and efficiency and therefore recommended that other models be considered.<sup>cxlii</sup>

*The Commission’s primary recommendation was to move, incrementally, towards a global system of payment*, in which providers would be prospectively compensated for all or most of the care that their patients may require over a contract period, as estimated from past cost experience and an actuarial assessment of future risk related to demographics and known conditions. Such a global system would shift some risk back to providers, which would be mitigated by patients’ health insurance coverage. In addition, payments would be based on meeting common core performance measures of high-quality care.<sup>cxliii</sup>

### **Integrated Care Model for Dual Eligible Population**

Massachusetts was one of 15 states selected by CMS to participate in an 18-month demonstration that integrated Medicaid and Medicare benefits for individuals dually eligible. The participation indicates that MassHealth plans to move to an integrated global payment model as discussed above. Providers should anticipate contracts to be awarded to integrated care entities in fall 2012. This would enroll approximately 115,000 dual eligible individuals ages 21 to 64 in an integrated care model. The model would cover both physical and behavioral services, including “Medicare Part A hospital services, Medicare Part B outpatient services, and Medicare Part B prescription drug coverage, current MassHealth Medicaid services, additional behavioral health services and community support services”.<sup>cxliv</sup>

What this means for providers: Care for dual eligibles will be managed and financed through blended Medicare and Medicaid funds. Provider entities will receive one blended payment for services rather than two separate payments.

Opportunity: Providers have the opportunity to become a qualified integrated care entity for contracts that will be awarded by Fall 2012. In addition, the contracted integrated care entities will create a provider network for services, human services specifically covered include administrative cost, case management, primary care and behavioral health services.

A global payment system will impact individuals if enrolled in the dual eligible integrated care model discussed above. Human services covered would include care coordination, some

community supports and behavioral health services. If applied in the human services field, such a payment structure would have advantages and disadvantages. Payments could be made prospectively, enabling providers to take a step ahead of immediate demands through updated technology and training. The payment would be blended across funding streams so providers would receive one payment for services rather than separate payments for services covered under each funding stream. This system would also encourage providers to serve clients efficiently, with performance measures in place to ensure quality. However, without an insurance mechanism to supplement the cost of providing care on a per-client basis, there is a possibility that actual service needs could outstrip projections and funds available to cover costs, which would have an adverse effect on providers and clients alike.

The shift away from FFS has already begun in Massachusetts. Blue Cross/Blue Shield of Massachusetts and some providers have agreed on global budgets with annual spending growth limits, quality incentive payments, and technical support for participating medical groups. As changes in the health payment structure occur, they could have impact on human services, specifically those that overlap in the realms of mental and behavioral health services.

The Executive Office of Health and Human Services recently went through a massive Purchase of Service (POS) reform to bring FFS payments in line across the health and human service provider network. The reform impacted the POS across agencies requiring the use of rate agreements, standardized rates, recognition of “fair” wages, and the use of

performance requirements in contracts. The reform resulted in a uniform FFS rate for providers contracting with multiple agencies for the same service.

Potential for Provider Participation: Payment Structures	
<b>Provider Opportunity:</b>	<ul style="list-style-type: none"> <li>• Money Follows the Person and Home and Community Based Waivers as payers</li> <li>• MFP transition services will include competitive procurements with independent living, behavioral health, and disability contractors</li> <li>• Movement towards global system of payment for health care</li> </ul>
<b>Provider Challenge:</b>	<ul style="list-style-type: none"> <li>• React to changes with Medicaid/Medicare dual eligibility and Health Care Reform</li> <li>• Movement towards global system of payment for health care</li> <li>• Uniform Purchase of Service Reform (POS)</li> <li>• Fee for service reporting requirements and administration requirements</li> </ul>

# Appendix 1: Participant-Directed Services by State

State	Children's Support	Adults with Disabilities	Developmental Disabilities	Elderly / Aging / Disabled	Behavioral / Mental Health	HIV/ AIDS	Brain Injury	Veterans	Unspecified
Alabama		X		X					
Alaska				X					X
Arizona			X	X	X				
Arkansas		X		X				X	
California	X	X		X					
Colorado	X		X	X	X	X	X		
Connecticut		X	X	X	X	X	X	X	
Delaware		X		X					
District of Columbia								X	
Florida	X	X	X	X		X	X	X	
Georgia	X		X	X			X	X	
Hawaii		X		X					
Idaho		X	X	X			X		
Illinois	X	X	X	X	X	X	X	X	
Indiana	X	X	X	X	X	X	X		
Iowa	X	X	X	X		X	X		
Kansas	X	X	X	X	X	X	X		
Kentucky	X	X		X	X	X	X		
Louisiana	X		X	X	X	X	X	X	
Maine		X		X				X	
Maryland		X	X	X	X	X	X	X	
Massachusetts	X	X	X	X	X		X	X	
Michigan	X	X	X	X	X	X	X	X	
Minnesota	X	X	X	X	X		X	X	
Mississippi				X			X		

State	Children's Support	Adults with Disabilities	Developmental Disabilities	Elderly / Aging / Disabled	Behavioral / Mental Health	HIV/ AIDS	Brain Injury	Veterans	Unspecified
Missouri	X	X	X		X	X	X		
Montana	X	X	X	X	X	X	X		
Nebraska	X	X	X	X	X	X	X		
Nevada	X	X	X	X	X	X	X		
New Hampshire	X	X	X	X	X	X	X	X	
New Jersey		X	X	X	X	X	X	X	
New Mexico		X	X	X	X	X	X		
New York		X	X	X				X	
North Carolina		X	X	X	X	X	X		
North Dakota	X		X						
Ohio		X	X	X	X	X	X	X	X
Oklahoma	X	X		X					
Oregon	X			X				X	
Pennsylvania		X		X					
Rhode Island	X	X	X						
South Carolina				X		X		X	
South Dakota								X	X
Tennessee		X	X	X					
Texas	X	X	X	X	X	X	X	X	X
Utah	X	X	X		X	X	X		
Vermont	X	X	X	X				X	
Virginia	X	X	X	X	X	X	X	X	
Washington		X	X	X	X	X	X	X	
West Virginia		X		X					
Wisconsin		X	X	X				X	
Wyoming			X	X					

Source: Program Listings from the National Resource Center for Participant-Directed Services: <http://web.bc.edu/libtools/insights-publications.php>. An "X" indicates a population named either as a target population for a listed program or as a population covered under a listed HCBS waiver.

## Notes

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<sup>xxxvi</sup> Across the country, states have been sued for not acting quickly enough to de-institutionalize individuals. In Massachusetts for example, the state was the subject of two separate lawsuits of this nature. The first, Rolland v. Patrick, filed in 1998, alleged that Massachusetts citizens with developmental disabilities were "unnecessarily

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admitted to and inappropriately confined in Massachusetts nursing homes." Then, in 2001, the Rosie D. v. Romney case alleged that children were being denied "comprehensive and medically necessary behavioral health treatment that would enable them to receive services and supports at home and in their own communities instead of psychiatric hospitals and residential facilities."

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<sup>ii</sup> *Ibid.*

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<sup>lvii</sup> Interview with Jhamirah Howard, Kaiser Family Foundation, October 5, 2011.

<sup>lviii</sup> Interview with Jhamirah Howard, Kaiser Family Foundation, October 5, 2011.

<sup>lix</sup> Interview with David Besancon, Maxim Healthcare Services, Columbus (OH), November 30, 2011.

<sup>lx</sup> *Ibid.*

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